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INFORMATIONAL LETTER #2000-8

DATE: June 28, 2000

TO: ALL IDAHO NURSING FACILITIES

FROM: LORETTA TODD, R.N., Interim Chief
Bureau of Facility Standards

SUBJECT: **MDS STANDARD STATE SYSTEM CHANGES**

Health Care Financing Administration (HCFA) has developed two separate initiatives that will improve the accuracy of information received in the State database. Effective May 22, 2000, several important changes were made to the MDS Standard State System regarding record acceptance and editing procedures.

Because MDS data is being used for the Prospective Payment System (PPS), quality monitoring, research and policy development, it was imperative that these changes occur. These new modifications involve:

- ✓ elevation of selected current non-fatal errors to fatal record errors that will result in record rejection;
- ✓ addition of new fatal record errors that will also result in record rejection; and,
- ✓ updating the system to appropriately produce fatal error messages when ampersand filled values occur in MDS items that are active for a record.

In addition, a new mechanism was incorporated to enable facilities to make an automated request to correct errors of any type in records that have been accepted in the State database instead of the manual key change request form. Through the use of a new MDS Correction Request Record, modification or inactivation of records will be allowed.

If your vendor has not incorporated the new 1.10 data specification MDS software, the facility will still be able to submit data using the older version. With the stricter enforcement of edits, or until your software vendor incorporates HCFA's revised standard edits, it is highly probable that your facility may experience a temporary increase in the number of records rejected. Therefore, we recommend that close attention be paid to the Final Validation Report after each upload to the State database. However, with the stricter edits and enhanced record rejection, the need for corrections should be infrequent.

Just as a reminder, these are the key changes that took effect on May 22, 2000, with the version 1.10 upgrade:

1. ASMT_LCK and CARE_LCK no longer required before submission to database.
2. Submission timing based upon completion dates instead of lock dates.
3. Submissions will occur within 31 days of the event or completion date.
4. Tracking forms submitted within 31 days from the date at A4a for Reentry or R4 for Discharge.
5. Assessments submitted within 31 days of VB4 for comprehensive assessments and R2b for other assessment.
6. Electronic mechanism to correct errors of any type in the State database.

If after reviewing the manual, you need additional clarification please call Jan Courtney at the MDS help desk 1-800-263-5339 or 378-5898 or Debby Ransom or Jack Weinberg at (208) 334-6626.

Loretta Todd

LORETTA TODD, R.N., Interim Chief
Bureau of Facility Standards

LT/nah
Enclosures
cc: Idaho Health Care Association

Health Care Financing Administration

Long Term Care Resident Assessment Instrument Version 2.0

Draft Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form

March, 2000

The *Draft Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form* is published by the Health Care Financing Administration (HCFA) and is a public document. It may be printed and copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long term care facilities.

Authors of this document include Cindy Hake, Bob Godbout, David Wilcox, and Pauline Swalina.

HCFA ACKNOWLEDGEMENT

We wish to thank the States of Maine and Washington, as well as providers and MDS software vendors in those States, for participating in the MDS Correction Policy Pilot Project. We expect that the new policies and procedures tested in the pilot will improve quality of MDS data and improve the operation and usefulness of applications which use those data.

Please submit your comments and questions about MDS correction policy or the related clinical processes to your State RAI Coordinator. Please submit your comments and questions about automation and submission requirements to your State MDS Automation Coordinator.

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CHAPTER 1

OVERVIEW OF MDS CORRECTIONS AND REVISED POLICIES

Prior to the development of this new facility driven, electronic mechanism for correcting information in MDS records (assessments and Discharge and Reentry Tracking forms) in the State MDS database, facilities only had a mechanism to correct errors if they were in KEY fields, or errors that were Major. An error is Major if the resident's overall clinical status has been misrepresented on the MDS or the care plan derived from the erroneous assessment does not suit the resident. Facilities have always had an option to correct Major errors. The correction process for Major errors is to perform additional assessments. The correction process for non-Major errors has been limited to errors in KEY fields and has involved a manual request from the facility to the State, followed by a manual process at the State to correct the error. Historically, facilities have not had an easy mechanism to correct errors in the State MDS database that were not Major and not in KEY fields, for example, transcription errors, data entry errors, or errors caused by MDS vendor software. Facilities historically have also not had a mechanism to inactivate records that never should have been submitted to the State MDS database (e.g., test records or records for events that did not occur).

Because of the lack of an easy mechanism to correct non-KEY and non-Major errors in MDS records in the State database, there is concern about both the accuracy of MDS information in the State database and potential inconsistencies between a facility's MDS record and the copy of it in the MDS database at the State. It is important that information in the MDS databases be accurate, since that information provides the basis for quality and payment systems, such as quality monitoring based on Quality Indicator (QI) reports, the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS), and State Medicaid nursing home reimbursement programs (in some States). MDS information is also used for consumer reports, research, and policy development, as well as provider feedback reports for use in facility internal Quality Improvement or other programs.

HCFA has developed two separate initiatives that, in combination, will greatly improve the accuracy of information in the State MDS databases. The effective date for both of these initiatives is April 28, 2000. The first initiative involves enhancement of the MDS record editing process to include stricter enforcement of existing edits. Most existing errors or warnings will be elevated to fatal errors, resulting in rejection of the record. The second initiative for improving the accuracy of information in the MDS database at

the State involves the implementation of a new mechanism for facilities to submit electronic requests to correct errors ***of any type*** (not just errors in KEY fields) in MDS records that reside in the State database. This new correction mechanism involves the use of an MDS Correction Request Form to allow either ***modification*** or ***inactivation*** of a record.

Although it is important to expand facility options for corrections, and to provide an easy mechanism to correct errors in MDS records in the State database, we anticipate that the need for corrections will be rare. As a direct result of the enhanced editing and record rejection process, very few records with errors will be accepted by the State MDS system.

1.1 Enhanced Record Rejection

Under this enhanced process, the MDS system at the State will reject (not accept into the State database) an MDS record (assessment, or Discharge or Reentry Tracking form) that contains any out of range values (e.g., item coded 5 when valid responses are 1, 2, 3, or 4); that contains selected inconsistencies between item responses (e.g., skip pattern ignored); that omits critical information (e.g., information that identifies the facility, the resident, or the type of record); that contains impossible date relationships (e.g., admission date earlier than birthdate); that involve miscalculations for selected items (e.g., a miscalculated RAP trigger); or that violates selected formatting requirements (e.g., such as misplaced decimal in an ICD-9 diagnosis code). Other edits will continue to result in non-fatal errors. Examples of some types of errors which will remain non-fatal include: errors involving timing between assessments and assessment sequence; errors involving certain formatting requirements (e.g., text entries that are not upper-case); some inconsistent item responses; and some calculated items (e.g., RUGs case mix classifications).

Initially, until facilities become accustomed to the enhanced edits, or until MDS software vendors effectively incorporate the HCFA standard edits, some facilities may experience a temporary increase in the number of MDS records rejected. The facility submission routine should allow for timely correction and resubmission of rejected records. Consider the case where the facility submits a record with only 5 days remaining in the 31 day submission timeframe. There is no provision to allow additional time to resubmit rejected records, and the facility only has these 5 remaining days to notice the rejection, correct and resubmit the record, and have the record accepted into the State database.

Facilities should pay particular attention to their Final Feedback reports, so as not to overlook notice of rejected records. If facility staff overlook notice of a rejected record,

they might assume that it has been accepted in the MDS database. After an appropriate period of time, the State system will consider that record overdue or missing. This will be reflected in management reports provided to the State.

The system enhancements to accommodate corrections will be accompanied by revised error messages. The length of the error messages has been increased to allow better description of the error and better understanding of possible causes. These new messages should facilitate trouble shooting.

1.2 Revised MDS Record Locking Requirements

Both the enhanced rejection and the new MDS correction policies cause potential problems with the traditional MDS assessment locking policy. Analysis has indicated that the traditional Assessment Locking and Care Planning Locking requirements may produce complexities when combined with the new Correction Policy. Consider the following example. A facility creates and locks an MDS record in preparation for submission. A data error is then discovered in the locked record before submission. Since the record is locked, the facility cannot change the record. The only alternative is to submit the record in error. The new Correction Policy would then allow the facility to request correction of the record once it is in the State database. However, requiring the facility to submit a known error in order to correct it is an awkward process. It would seem much easier if the facility could simply correct the original record anytime before submission. In this case, the record would not be locked in the facility, but rather would be locked upon its acceptance into the State database.

There are even more severe problems when record locking in the facility is required with the enhanced record rejection. With enhanced record rejection, the traditional requirements concerning the locking of MDS data records will become even more difficult for the facility to manage. Traditional record locking requires that the record be locked in the facility, prior to submission to the State. Only after locking and then submission to the State, will the facility be informed if a record is rejected because of data errors. When a record is rejected, the facility must unlock the record, correct only the errors causing rejection, and resubmit the record. If a record must be unlocked and corrected, then the usefulness of the locking concept is questionable.

Because of such problems, a revised approach to record locking, that is more compatible with correction policy, is being implemented. ***Revised policy removes the requirements that records be locked in the facility before submission and acceptance into the State database.*** The Assessment Lock Date (ASMT_LCK) and Care Planning Lock Date (CARE_LCK) are no longer required to be accounted and submitted. ***With this revised approach, an MDS record is considered locked when***

accepted into the State database.

1.3 Traditional MDS Editing Time Frame Remains in Effect

The concept of locking an MDS record was originally developed to insure the clinical integrity of the MDS assessment process. The "Long Term Care Resident Assessment Instrument User's Manual" for MDS 2.0 presents this concept. That manual describes the MDS assessment as being completed according to the regulatory timeframe. Amendments can then be made to any item during the next 7 day period, provided that the same Assessment Reference Date (MDS item A3a) is used. In the past, no changes could be made after this 7 day editing period that follows completion of an assessment. The intent in requiring a limited editing period was to ensure the timely finalization and clinical integrity of MDS assessments.

The revised locking policy does not extend the MDS editing period beyond the traditional 7 days. ***The traditional 7 day editing period following assessment or tracking form completion will still play an important role in the MDS process. The end of the 7 day time period remains important because that is the point at which the care plan is established or updated based on information in a completed assessment. If the record is not submitted and accepted by the end of the 7 day editing period, then a formal, paper audit trail must be maintained in the facility for any subsequent changes, until the record is accepted by the State. Any corrections after the editing period must reflect resident status and conditions as of the original Assessment Reference Date.***

A Major error occurs if the assessed view of the resident's overall clinical status is inaccurate or the care plan inappropriate. ***If a Major error is detected more than 7 days after completion of an assessment, then the facility should not only correct and submit that original assessment but also should perform a new "Significant Correction or Significant Change" assessment and update the care plan.***

1.4 Revised MDS Submission Timing Requirements

HCFA's MDS automation requirement provides that MDS assessment records, discharge tracking records, and reentry tracking records must be electronically submitted at least monthly from the facility to the State. A further requirement stipulates the timely submission of each record.

In the past, submission timing specifications were based upon record locking dates. However with discontinuation of the requirement to lock records in the facility prior to acceptance, the submission requirement can no longer be based on the lock dates.

Submission timing is now based upon completion dates rather than locking dates as follows:

Tracking Forms. The previous submission timeframe required discharge and reentry tracking form records to be submitted within 31 days of record locking. To be consistent with the revised locking for assessments, the revised timeframe is to ***submit tracking forms within 31 days of the event*** (the date at MDS item A4a for a Reentry or R4 for a Discharge). The tracking form submission timeframes are detailed in Table 1 below.

Assessments. The previous submission timeframe required assessment records to be submitted within 31 days of the final lock date (CARE_LCK for comprehensive assessments and ASMT_LCK for other assessments). The revised timeframe is to ***submit assessments within 31 days of the final completion date*** (VB4 for comprehensive assessments and R2b for other assessments). This assessment submission timeframe is detailed in Table 1 below.

Correction Requests. Correction Requests are discussed throughout the remainder of this manual. Correction requests involve a new type of submission record. The required submission timeframe for correction requests is ***to submit within 31 days of completing the request*** (the date at item AT6 on the Correction Request Form). The correction request submission requirement is listed in Table 1.

TABLE 1
SUBMISSION TIMEFRAME FOR MDS RECORDS

Type of Record	Primary Reason (AA8a)	Secondary Reason (AA8b)	Final Completion Or Event Date	Submit By
Admission Asmt.	01	all values	VB4	VB4 + 31
Annual Asmt.	02	all values	VB4	VB4 + 31
Sign. Change Asmt.	03	all values	VB4	VB4 + 31
Sign. Correction Full Asmt.	04	all values	VB4	VB4 + 31
Quarterly Asmt.	05	all values	R2b	R2b + 31
Sign. Correction Quarterly Asmt.	10	all values	R2b	R2b + 31
Asmt for Medicare PPS only (with AA8a = 00)	00	1 thru 5, 7, 8	R2b	R2b + 31
Discharge Tracking	06, 07, 08	blank	R4	R4 + 31
Reentry Tracking	09	blank	A4a	A4a + 31
Correction Request	all values	all values	AT6	AT6 + 31

Definitions of important dates, such as final completion and event dates, are provided in Appendix A.

1.5 HCFA Recommendations Concerning Submission Timing

HCFA's submission requirement is that an assessment record should be submitted within 31 days of final completion. However, with record locking redefined as the point of acceptance into the State database, consideration must be given to shortening the submission timeframe requirement. A 31 day period between completion and locking is clearly undesirable and may compromise the clinical integrity of MDS assessments. Consider an example using an September 1 Assessment Reference Date for observing a resident for a Quarterly assessment. The assessment is completed on September 14, within the regulatory guidelines. The record is then submitted and accepted (locked) on October 15 (31 days after completion). There is concern that changes might be made to the MDS, a clinical document representing the resident's condition on September 1, as long as 45 days after that date.

The dilemma is that locking records in the facility (before submission) creates excessive complexity when coupled with enhanced record rejection and the new Correction Policy, while locking records upon acceptance compromises the clinical integrity of the MDS ***if the current, wide submission window is maintained***. A solution under consideration by HCFA is to change the regulation to reduce the submission time frame. Ideally, the submission requirement could be shortened to 7 days after completion. This would mirror the traditional MDS locking policy. Until such time as the regulation can be changed, HCFA strongly recommends that facilities routinely submit within 7 days of completion.

The current 31 day submission window seemed appropriate several years ago, when facility automation was in its infancy and many facilities were employing diskette submission through the mail. Today, with better facility automation and the requirement for modem transmission to a Standard State MDS system, a shortened submission window seems appropriate and should simplify correction and documentation processes for the facility. Analysis of MDS records submitted to the States has indicated that the vast majority of providers are submitting within a week or two. With a shortened submission window, if a record containing an error does make it into the State database, that error can still be corrected via the new Correction Policy.

1.6 Use of an MDS Correction Request Form

A new, one-page MDS Correction Request Form is being implemented as part of MDS Correction Policy. This form contains the minimum amount of information necessary to enable correction of erroneous MDS data previously submitted and accepted into the State MDS database. A Correction Request Form should only be used for records that actually have been accepted and reside in the State database. Do not use the Correction Request Form for a record that has not yet been submitted, or for a record that has been submitted, but rejected. If the record in error has not been submitted, or if it has been submitted and rejected, then the facility should correct that record "in-house", before submission or resubmission. Anytime corrections to a record are made, whether the record has been accepted by the State or not, the corrected information should reflect the resident's status as of the date of the ***event*** (Assessment Reference Date, Discharge Date, or Reentry Date).

The facility should be able to demonstrate that corrective action has been taken within 14 days of the date an error is detected in a record already accepted in the MDS database. This corrective action involves completion of a Correction Request Form, specifying the requested action (modification or inactivation). As with completion of the original assessment, when modifying or inactivating assessment information, the facility is responsible to ensure the participation of the appropriate health care professionals.

The following describes the parameters for timing and frequency of correcting (modifying or inactivating) information in the State database:

- **Types of corrections that should be made.** Facilities should correct any errors necessary to insure that the information in the State MDS database accurately reflects the resident's identification, location, overall clinical status, or payment status. It is not HCFA's intent that a record be corrected when the only errors are trivial (e.g., the lifetime occupation in MDS item A6 has been misspelled). States have the option to require more extensive correction. If there is uncertainty about the correction requirements in a particular State, the State RAI coordinator should be contacted for clarification.
- **Time length between error detection and correction.** It is expected that a Correction Request Form will be completed within 14 days of error detection. If circumstances have precluded timely completion, corrections should be made as soon as possible. Documentation must be included in the resident's clinical record indicating the date(s) that error(s) were detected.
- **Time length between acceptance and correction.** A correction can be submitted for any accepted record, regardless of the age of the original record. For example, a record accepted 2 years ago can still be modified. However, certain limitations might apply for specific system applications. For example, a time limit may be placed on using corrections for making payment adjustments.
- **Correction of non-current records.** A record may be corrected even if subsequent records have been accepted for the resident. For example, an admission assessment may be corrected after one or more subsequent quarterly assessments have been accepted.
- **Number of items changed in a modification request.** There is no limit to the number of items that can be changed in one assessment or tracking form record with a single modification request.
- **Number of modification requests for a record.** There is no practical limit to the number of sequential modifications that may be requested for a record (up to 99 sequential changes are allowed). If a record has been previously modified and additional errors are detected, then an additional correction should be submitted. Similarly, if a modification itself is in error, then a subsequent correction should be submitted.
- **Transition rule with implementation of correction policy.** For records accepted before implementation of correction policy, the facility may optionally make corrections, however correction of these records is not required. It is not HCFA's intent that facilities review and correct all historic records submitted before

implementation of correction policy. For MDS records accepted after implementation of correction policy, facilities should correct any errors that misrepresent the resident's identification, location, overall clinical status, or payment status.

1.7 Components of the Correction Request Form

The Correction Request Form contains two sections: the "Prior Record Section" and the "Correction Attestation Section". The Prior Record Section is primarily used as a record locator. That is, it identifies the erroneous record so that it can be located in the State MDS database.

The Correction Attestation Section includes the following information:

1) the sequence number of this correction, relative to other corrections that may have been made to the same original record;
2) the type of correction requested (modification or inactivation);
3) the reason(s) the modification or inactivation is necessary;
4) the names of the facility staff attesting to the accuracy and completeness of the corrected information, relative to the resident's status as of the event date of the erroneous record (MDS item A3a for an assessment, MDS Item R4 for a discharge, and MDS Item A4a for a reentry);
5) the signatures of these facility staff; and
6) the dates of the attestations.

Note that the Correction Request Form does ***not*** include a section for specifying which Item(s) are in error. On the Correction Request Form, the facility need not specify which items are being corrected. Whenever items are being corrected using a modification request, an entire, corrected electronic assessment or tracking form will be submitted ***along with*** the Correction Request Form (see "1.9 Components of a Submission Record"). The standard MDS system at the State is programmed to identify any differences between the erroneous record and the record submitted to correct it. The corrected record essentially "replaces" the erroneous record in the database and becomes the current version of the record to be used in standard system applications, such as QIs. The erroneous record is placed in a "history" file, and the State MDS system tracks sequential changes to records.

The Correction Request Form serves several purposes: (1) to request correction of error(s) in an MDS record (assessment, Discharge Tracking form, or Reentry Tracking form) that has already been accepted by the MDS system at the State; (2) to identify

the prior, erroneous record so that it can be located in the State database; and (3) to attest to the accuracy of the correction request. Using the form, a facility specifies whether the request is to ***Modify*** or to ***Inactivate*** a record.

1.8 Modification vs. Inactivation

Since stricter edits and enhanced record rejection are being coupled with the implementation of Correction Policy, the need for corrections should be infrequent. Fewer records with errors will be accepted by the database. Although corrections should be made when appropriate, facilities submitting high volumes of correction requests should examine their RAI procedures, the adequacy of their software, and how well staff understand the RAI coding instructions.

An important concept is whether a record is ***valid*** or ***invalid***. A record is considered to be ***invalid*** in any of the following cases:

1) It was a ***test record*** inadvertently submitted as a production record.
2) The event did not occur.
   a. The record submitted does not correspond to any actual event. For example, a discharge tracking form was submitted for a resident, but there was no actual discharge. There was ***no event***.
   b. The record submitted identifies the ***wrong resident***. For example, a discharge tracking form was completed and submitted for the wrong person.
   c. The record submitted identifies the ***wrong reasons for assessment***. For example, a Reentry Tracking Form was submitted when the resident was discharged.
3) Inadvertent submission of an inappropriate, ***non-required record***.

When there are errors to be corrected, a decision must be made whether to modify or inactivate the erroneous record. If a valid record is found to contain erroneous information, then that record should be modified. If a record is invalid, it should be inactivated. Even if an invalid record in the State database contains other errors, this invalid record should not be modified. Any invalid record should be inactivated.

Modification. A ***modification*** should be requested when a ***valid*** MDS record (assessment or tracking form) is in the State MDS database, but the information in the record contains errors. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, or errors caused by vendor software. Examples of error types are provided in Chapter 3. When a valid record is in error, the facility

completes a Correction Request Form indicating that "modification" is the action requested at Item AT2 on the form. In addition, for a modification, the facility also completes a corrected MDS assessment or tracking form. The corrected MDS assessment or tracking form must accurately reflect the resident status as of the original Assessment Reference Date for an assessment, Discharge Date for a discharge tracking record, or Reentry Date for a reentry tracking record.

When a record is modified, the standard system at the State moves the prior, erroneous version of the record to the facility's submission history file to allow tracking of sequential changes. Records in the facility's submission history file are not used in standard system applications. Only the current version of a record is active and used in standard applications.

There is no automatic mechanism to "undo" a modification and "recall" the prior version of the record from the submission history file. Consider the case where a facility submits a record and later modifies it. Then the facility discovers that the earlier record was correct after all. The later (active version) of the record is in error. In this case, the facility should resubmit the earlier (correct) version of the record with a new modification request. The standard system at the State will then replace the erroneous record with the correct one as the active version. A modification can only be "undone" by submission of an additional modification request (including the correct record and the Correction Request Form).

When a record is modified, the facility should not change the original completion dates (MDS items R2b, VB2, and VB4) of the record, unless the facility can demonstrate that these dates themselves are in error. These dates are intended to document the RAI process and are not intended to be updated to the time of a subsequent correction (see also the documentation requirements as discussed in Section 1.10 of this document).

One complication that can occur with the modification of a comprehensive assessment record is the possibility that RAPs will trigger differently (newly trigger or untrigger) as a result of changes made to the assessment record. Facilities should establish a procedure whereby RAPs are recalculated anytime corrections involving RAP trigger items are made to a comprehensive assessment record. On a comprehensive assessment, anytime the RAP calculations are inconsistent with the corresponding MDS items, the assessment record will be rejected. This applies whether the comprehensive assessment record is an original record or a modification. Whenever RAPs trigger differently on a corrected comprehensive assessment, the corrected RAP information must also be submitted. In addition, the facility must determine whether there is an impact on the current care plan. If there is impact on the current care plan, then in addition to the modification, the facility must complete and submit a new

Significant Correction or Significant Change assessment, whichever is appropriate (see Section 1.11).

It is very important to understand that a modification to an MDS record will only correct information on that specific record. Consider the case where the resident's birthdate has been submitted in error on an admission assessment and then again on the first quarterly assessment. If the facility submits a correction request to modify the birthdate on the quarterly, then this action will only correct the birthdate on for that quarterly assessment. This modification does not fix the birthdate problem "in general". No change will have been made to the birthdate on the admission assessment. The admission assessment can only be corrected by a modification pertaining to that specific assessment. In general, a modification only corrects a single record. If there are multiple records with the same error, separate modifications must be submitted for each record.

Inactivation. An ***inactivation*** should be requested only when an ***invalid*** record has been accepted into the State database. For an invalid record, the facility completes a Correction Request Form indicating that "inactivation" is the action requested at Item AT2 on the form. Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid. When the facility inactivates a record, the standard system at the State does not delete the record. Inactivated records remain in the facility's submission history file to allow tracking of sequential changes. However, inactivated records are not used in standard system applications.

There is no automatic mechanism to reactivate a record that has been inactivated. Consider the case where a valid discharge is accepted into the State database for a resident, but this valid discharge is later inadvertently inactivated. There is no means to "undo" the inactivation and thereby "reactivate" this discharge. Instead, the facility must submit the discharge record again. An inactivation can only be "undone" by resubmission of the record.

Consider another case where a record has been successfully modified and now has a prior version in the facility's submission history file, in addition to an active current version. An inactivation of the current version will not "recall" the prior version from submission history. Whenever an inactivation is processed for a record, there is no remaining active version of that record. After an inactivation, all versions of that record are stored only in the facility's history file.

It has been suggested that inactivation of a ***valid*** record followed by resubmission of a corrected version of the same record could substitute for the modification process.

This is completely inappropriate. The use of the inactivation process is permitted only for invalid records. It is anticipated that the inactivation process will be used rarely.

1.9 Components of an MDS Submission Record

A major change with the new Correction Policy is that ***all*** submission records now include new sections to accommodate information contained in a Correction Request Form. A single submission record now includes areas for ***both*** an MDS record (assessment, Discharge Tracking form, or Reentry Tracking form) ***and*** correction request information. The "Overview of MDS Submission Record" in Figure 1-1 depicts the contents of a submission record. Submission records may include either data from the MDS assessment or tracking form, or information from the Correction Request Form, or both, depending on whether the submission record is for an original MDS record, an inactivation request, or a modification request.

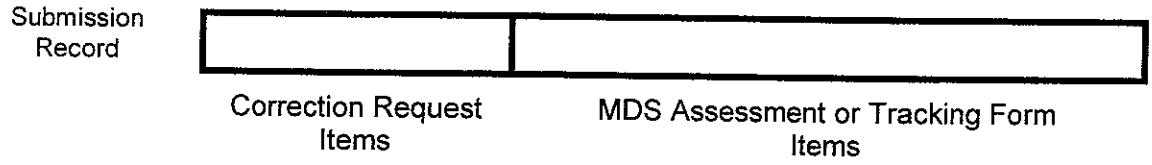
For a modification, ***both*** the information on the Correction Request Form ***and*** the corrected assessment or tracking form is encoded into a single, electronic submission record according to HCFA's standard MDS Data Specifications. This submission record includes data from the ***entire***, corrected MDS assessment or tracking form, ***not just*** the corrected values for the items that were in error.

For an inactivation, the facility encodes the information from the Correction Request Form into an electronic submission record according to HCFA's standard MDS Data Specifications. In this case, the submission record contains the correction request information ***only***, and assessment or tracking form information must be blank. This provides sufficient information for the erroneous MDS record to be located and inactivated in the State database. If the assessment or tracking form information is not blank, the inactivation request will be rejected. This rejection criterion has been adopted as a safeguard to insure that other records are not mistaken for inactivation requests.

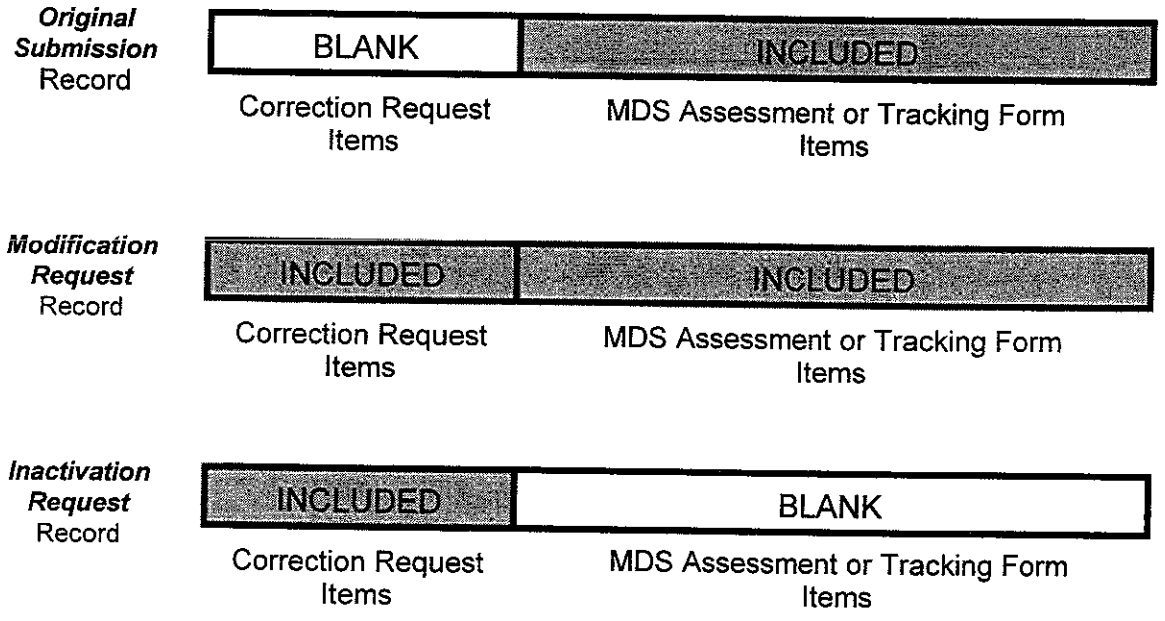
Figure 1-1.

OVERVIEW OF MDS SUBMISSION RECORD
(Version 1.10 of the MDS Data Specifications)

With the new MDS 2.0 Correction Policy, previously unused space in the submission record has been assigned to accommodate information on the Correction Request Form. A submission record now consists of areas devoted to MDS Assessment or Tracking Form items ***and*** areas devoted to Correction Request Form information as follows:



The contents of a submission record vary depending upon whether the record is an original submission, a modification request, or an inactivation request, as displayed below:



1.10 Retention of Correction Request Forms and Substantiating Documentation

A hard copy of the completed MDS Correction Request Form, including the signatures of the facility staff attesting to the completion and accuracy of the corrected record, must be attached to the appropriate MDS form and retained in the active clinical record for 15 months. In addition, there must be documentation in the resident's clinical record that clearly substantiates the accuracy of the corrected information, relative to the resident's actual status as of the ***event date*** of the erroneous record (MDS item A3a for an assessment, MDS Item R4 for a discharge, or MDS Item A4a for a reentry). In the case of a modification, a facility must correct the original MDS form or a copy of that form, using standard medical record procedure, clearly indicating all items that have been changed, the date of the change, and the corrected values. The modification request and attached corrected MDS form must be maintained in the resident's clinical record for 15 months.

When more than one modification is performed, a facility must document the sequence of corrections on either the original MDS form or copies of that form. For each set of corrections, a Correction Request Form must be attached to the corrected MDS form documenting the associated corrections. It is acceptable to have multiple Correction Request Forms attached to a single MDS form, as long as that MDS form documents all corrections made. This documentation must be legible.

Consider the case where a modification is required because there are items in error in the electronic record in the database at the State but not on the paper MDS form at the facility (e.g., there has been a data entry error). The Correction Request Form must still be attached to the MDS form in the resident's clinical record. Since these items are already correct on the MDS form, they cannot be "corrected" on that form. However, documentation should be included on the MDS form marking which items had data entry errors. If RAPs on a comprehensive assessment were electronically calculated based on the items in error, then the RAPs may also be in error. For this reason, RAPs should be recalculated and then corrected on the comprehensive assessment. Whenever RAPs trigger differently on a corrected comprehensive assessment, the facility must determine whether there is an impact on the current care plan. If there is impact on the current care plan, then in addition to the modification, the facility must also complete and submit a new Significant Correction or Significant Change assessment, whichever is appropriate (see Section 1.11). The care plan must also be updated based on this new assessment.

In the case of an inactivation, a facility must simply attach the Correction Request Form to the erroneous MDS form to be inactivated. The inactivation request and erroneous form should then be maintained in the resident's clinical record. Retention of

information in a resident's clinical record is obviously not an option in the event that the resident did not actually exist (e.g., fabricated test record) In this case, the inactivated record must still be retained, however it may be kept in a common file.

1.11 Regarding Significant Correction of Prior Assessments and Significant Change in Status Assessments

Modifying MDS assessments insures neither a current, accurate view of the resident's overall clinical status nor the appropriateness of the current care plan. Even though an assessment is modified, a new Significant Correction or Significant Change assessment and an update to the care plan may also be required.

"Significant Correction of Prior" assessments are still a viable and important part of the clinical corrections process. ***The data modification process in no way precludes the need for "Significant Correction of Prior" assessments.*** If the resident's overall clinical status has been mis-represented on the MDS or if the current care plan does not suit the resident's needs, then a Major error has occurred. When a Major error is detected, a new "Significant Correction of Prior" assessment must be performed using a new observation period and a new Assessment Reference Date, and the resident's care plan must be updated using information from this new assessment. A data modification cannot be used in lieu of this important clinical process. If an MDS assessment that has already been accepted by the State MDS system contains a Major error, then ***both*** a correction request to correct that record in the database ***and*** a new "Significant Correction of Prior" assessment should be submitted. If the erroneous record in the database is not corrected, facility reports generated for standard system applications (e.g., QIs and payment) will not be accurate. The new "Significant Correction of Prior" assessment should be performed in order to ensure accurate assessment and care planning based on the resident's current status. A data correction cannot simply substitute for a "Significant Correction of Prior" assessment. To do so would jeopardize the clinical integrity of the MDS process.

Similarly, ***the data modification process in no way precludes the need for "Significant Change in Status" assessments.*** The data modification process is used to make corrections to insure that the data in the State database matches the actual assessed condition of the resident at the time of assessment (e.g., Assessment Reference Date at MDS Item A3a). If a resident experienced a significant change in status since that time, a data modification is completely inappropriate for reporting this change. Rather, when a resident has experienced a significant change in status, a new "Significant Change in Status" assessment must be performed, using a new observation period and a new Assessment Reference Date, and the resident's care plan must be updated using information from this new assessment. A data modification

cannot be used in lieu of a "Significant Change in Status" assessment, or to record changes in a resident's condition. To do so would jeopardize the clinical integrity of the MDS process.

1.12 Correction Request Form

A formal attestation statement certifying accuracy is being developed for all MDS forms (Assessment Forms, Tracking Forms, and the Correction Request Form). Revised forms including this formal attestation statement and the appropriate, accompanying signature lines will be implemented in June 2000. At that time, facilities must adopt all of the revised forms.

A draft Correction Request Form, with the label "Washington Pilot 10/14/1999" at the lower right, appears on the next page. Correction policy will be implemented on April 28, 2000 using this draft form. Starting then, facility staff must complete and sign this form for any correction. In June 2000, facilities must switch to the revised Correction Request Form with the new formal attestation statement and accompanying signature lines.

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Correction Request Form

Use this form (1) to request correction of error(s) in an MDS assessment record or error(s) in an MDS Discharge or Reentry Tracking form record that has been previously accepted into the State MDS database, (2) to identify the inaccurate record, and (3) to attest to the correction request. A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:
1. **Complete a new corrected assessment form or tracking form. Include all the items on the form, not just those in need of correction;**
2. **Complete and attach this Correction Request Form to the corrected assessment or tracking form;**
3. **Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and**
4. **Electronically submit the new record (as in #3) to the MDS database at the State.**

TO INACTIVATE A RECORD IN THE STATE DATABASE:
1. **Complete this correction request form;**
2. **Create an electronic record of the Correction Request Form; and**
3. **Electronically submit this Correction Request record to the MDS database at the State.**

PRIOR RECORD SECTION.
THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (***In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.***)

Prior AA1	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
Prior AA2	GENDER	1 Male 2 Female
Prior AA3	BIRTHDATE	Month — Day — Year
Prior AA5	SOCIAL SECURITY	a. Social Security Number
Prior AA8	REASONS FOR ASSESSMENT	a. Primary reason for assessment ASSESSMENT (Complete Prior Date item Prior A3a *ONLY*) 1 Admission assessment (required by day 14) 2 Annual assessment 3 Significant change in status assessment 4 Significant correction of prior full assessment 5 Quarterly review assessment 10 Significant correction of prior quarterly assessment 0 *NONE OF ABOVE* DISCHARGE TRACKING (Complete Prior Date item Prior R4 *ONLY*) 6 Discharged—return not anticipated 7 Discharged—return anticipated 8 Discharged prior ro completing initial assessment REENTRY TRACKING (Complete Prior Date item Prior A4a *ONLY*) 9 Rentry b. ***Codes for assessments required for Medicare PPS or the State*** *1 Medicare 5 day assessment* *2 Medicare 30 day assessment* *3 Medicare 60 day assessment* *4 Medicare 90 day assessment* *5 Medicare readmission/return assessment* *6 Other state required assessment* *7 Medicare 14 day assessment* *8 Other Medicare required assessment*
	PRIOR DATE	(***Complete one only***) Complete Prior A3a if Primary Reason (Prior AA8a) equals 1, 2 3 4 5, 10, or 0. Complete Prior R4 if Primary Reason (Prior AA8a) equals 6, 7 or 8. Complete Prior A4a if Primary Reason (Prior AA8a) equals 9.
Prior A3	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* Month — Day — Year
Prior R4	DISCHARGE DATE	*Date of discharge* Month — Day — Year
Prior A4a	DATE OF REENTRY	*Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)* Month — Day — Year

CORRECTION ATTESTATION SECTION.

	TION SEQUENCE NUMBER	(*Enter total number of attestations for this record, including the present one*)

AT2.	ACTION REQUESTED	1 MODIFY record in error (*Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY.* ***Proceed to item AT3 below.***) 2 INACTIVE record in error. (*Do NOT submit an assessment or tracking form. Submit the correction request only.* ***Skip to item AT4.***)
AT3.	REASONS FOR MODIFICATION	(***If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5***) a Transcription error b Data entry error c Software product error d Item coding error e Other error *If "Other" checked, please specify:* _____
AT4.	REASONS FOR INACTIVATION	(***If AT2=2, check at least one of the following reasons; check all that apply.***) a Test record submitted as production record b Event did not occur c Inadvertent submission of inappropriate record d Other reason requiring inactivation *If "Other" checked, please specify:* _____
	ATTESTATION	This space is reserved for formal attestation language to be included for national implementation of the MDS correction policy in the Spring of 2000.
AT5.	ATTESTING INDIVIDUAL NAME	a. (First) b. (Last) c. (Title)
	SIGNATURE	
AT6.	ATTESTATION DATE	Month — Day — Year

C[illegible]PLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT
[illegible]EST

A[illegible]. ATTESTA-

CHAPTER 2

THE PROCESS OF CORRECTING ERRORS IN MDS RECORDS

When facility staff detect an error in an MDS Assessment, Discharge Tracking form, or Reentry Tracking form some decisions need to be made and some actions taken. These decisions and actions are necessary to correct errors in an MDS assessment or tracking form record and to assure that the resident's current overall clinical status is accurately represented and the current care plan is appropriate.

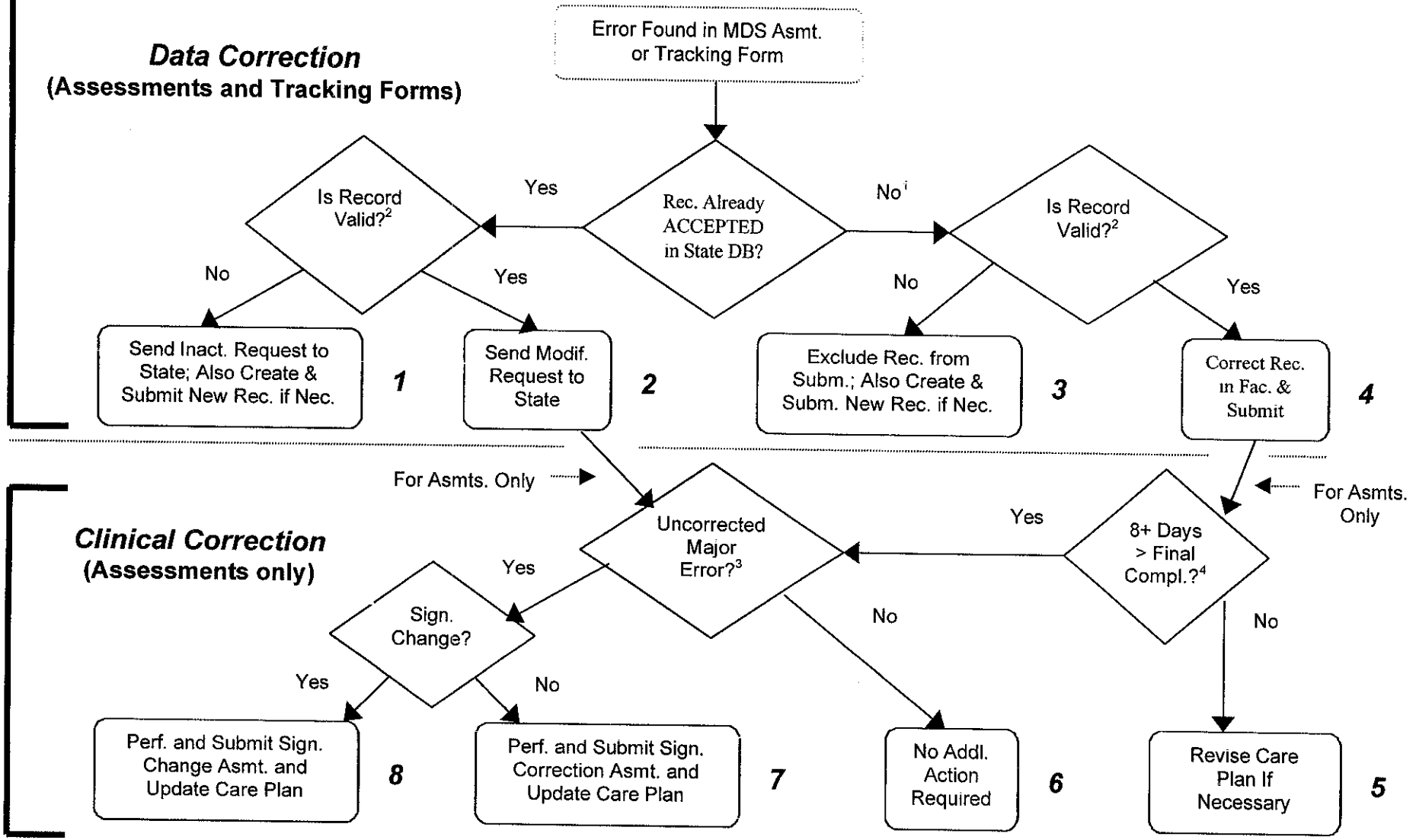
2.1 Correcting MDS Errors

The flowchart in Figure 2-1 depicts the sequential decision-making and action steps for facility staff to follow when an error is detected in an MDS assessment, Discharge Tracking form, or Reentry Tracking form. In this flowchart, the diamond shapes represent decisions that facility staff must make about the type of error(s), and the solid rectangles represent the corrective action a facility should take. There is a code number to the right of each solid rectangle to allow reference to that corrective action. For example the corrective action "Send Inact. [Inactivation] Request to State" is labeled as corrective action "***1***". The flowchart can be thought of as a "decision tree", and in that sense, it is a tool that facility staff may find useful in making appropriate corrections to MDS errors. There are nine different paths through the decision tree, each path being associated with a scenario involving specific facility actions. Each path involves one or two corrective actions. We will label the paths or scenarios with the code numbers of the actions involved. For example, the left most path (involving action "1" only) will be referred to as "Scenario 1". Similarly, the right most path (involving both actions "4" and "5") will be referred to as "Scenario 4/5". A later discussion will present more detailed step-by-step instructions to illustrate the actions required for each scenario.

The flowchart is divided in half horizontally by a dotted line. The top half is labeled "Data Correction" and this half involves correction of errors in an MDS assessment or tracking form record. The four actions in the top half (numbers "1" through "4") all represent Data Correction actions. The left side of the Data Correction area deals with correcting errors in MDS records that have already been submitted and accepted into the State database. The right side of the Data Correction area deals with correction of errors in MDS records that reside only in the facility and have not been accepted into the State database. The bottom half of the flowchart deals with "Clinical Correction" of

assessment records to assure that the resident's current overall clinical status is accurately represented and the current care plan is appropriate. The four actions in the bottom half (numbers "5 through "8") all represent Clinical Correction actions. Whenever there is an MDS assessment error, one must ask if there has been an effect on the currently assessed overall clinical status or the current care plan If so, it will be necessary to perform a new assessment and develop a new care plan.

Figure 2-1. CORRECTION POLICY FLOWCHART



[i]Record has not been data entered, has not been submitted, or has been submitted and rejected.
[2]The record is ***valid*** if ***event occurred***, ***resident*** and ***reasons for asmt.*** are correct, and ***submission is required***.
[3]The asmt. in error contains a Major error which has not been corrected by a subsequent assessment.
[4]Final completion is Item VB4 for a comprehensive and R2b for all other assessments.

When there are errors in a Discharge or Reentry Tracking Form, then only the Data Correction Process needs to be addressed. In contrast, errors in an MDS assessment require both the Data Correction process and the Clinical Correction process to be addressed. For assessments, these two correction processes are largely independent. Data Correction is appropriate for any MDS assessment error. Only Major assessment errors linked to an inaccurate current view of the resident's overall clinical status or inappropriate current care plan require Clinical Correction. A particular assessment error may require Data Correction but no Clinical Correction, while another assessment error may require both types of corrections. Remember that corrections should be made within 14 days of detecting an error.

Note that the paths (scenarios) in the flowchart always involve a Data Correction action (from the top half of the flowchart). All but two paths (Scenario 1 and Scenario 3) also involve a second Clinical Correction action (bottom half of the flowchart). ***This illustrates that any error always requires Data Correction and an assessment error will also require Clinical Correction depending on the circumstances.***

A Data Correction requires that the resident's clinical record contain both a signed attestation by an appropriate staff and documentation that substantiates the accuracy of the corrected information as of the event date for the original record (MDS Item A3a for an assessment, Item A4a for a Reentry Tracking form, and Item R4 for a Discharge Tracking form). Until the standard MDS system includes a mechanism to capture electronic signatures, a hard copy of the completed MDS Correction Request Form, including the signatures of the facility staff attesting to the accuracy of the corrected record, must be maintained with resident assessment information in the resident's clinical record. For a Clinical Correction, a new MDS assessment must be completed, placed in the resident's clinical record, and submitted to the State.

We will now work through the different scenarios in the flowchart in Figure 2-1. When facility staff detect an error in an MDS record (assessment, discharge, or reentry), the first thing they must do is determine whether the record has already been accepted by the standard MDS system at the State or not.

2.1.1 Errors in MDS Records in the State MDS Database

When an error is detected in an MDS record that has already been submitted and accepted into the MDS database at the State, facility staff should submit a request to correct the error(s) to the State, using an electronic MDS record which includes Correction Request Form information. The Correction Request Form information is used primarily to locate the erroneous record in the State database. It is also used to indicate whether the record in error requires ***Inactivation*** or ***Modification***.

2.1.1.1 Inactivating an Invalid MDS Record in the State MDS Database

A facility should inactivate a record in the State database when the record is ***invalid*** and should not actually have been submitted (action #1 in flowchart in Figure 2-1). A record is considered to be ***invalid*** in any of the following cases:

1) It was a ***test record*** inadvertently submitted as a production record.
2) The event did not occur.
   a. The record submitted does not correspond to any actual event. For example, a discharge tracking form was submitted for a resident, but there was no actual discharge. There was ***no event***.
   b. The record submitted identifies the ***wrong resident***. For example, a discharge tracking form was completed and submitted for the wrong person.
   c. The record submitted identifies the ***wrong reasons for assessment***. For example, a Reentry Tracking Form was submitted when the resident was discharged.
3) Inadvertent submission of an inappropriate, ***non-required record***.

To inactivate the record, the facility completes a Correction Request Form, indicating that the action requested is inactivation (Correction Request Form Item AT2 = 2). The submission record contains ***only*** the correction request information (see "Overview of MDS Submission Record" in Figure 1-1 in Section 1.9). This provides sufficient information for the erroneous MDS record to be located and inactivated in the State database. For an inactivation, corrected MDS assessment or tracking form data is not included in the submission record. If assessment or tracking form items are included, the record will be rejected. When the State accepts and processes the inactivation request, the record is inactivated in the State database. Refer to Table 2-1 for **Scenario 1** below for the steps involved in inactivating an invalid record in the State database.

While cases necessitating inactivation should be rare, it is still important to have a correction mechanism when they do occur. Inactivated records are not actually removed from the State database; rather, they remain in a history file and are flagged as inactive. Inactivated records will not be used in many standard system applications such as resident roster reports and QI reports. However, inactivated records remain available as part of the history of records submitted by the facility and can be used to reconstruct historical reports or to generate analytical reports designed to review the nature and frequency of corrections.

Once a record has been inactivated, it cannot be reactivated. If a facility inadvertently

inactivates a valid record, they must resubmit that valid record.

Table 2-1.

SCENARIO 1 **Invalid Record in the State Database**

• The facility discovers that an invalid MDS assessment or tracking form record has been submitted. The record is invalid because it represents a test record, the event did not occur, the record indicated the wrong resident or wrong reasons for assessment (MDS Items AA8a and AA8b), or the record was not required to be submitted
• Investigation indicates that this invalid record has been accepted into the State MDS database.
• The record in the State database is invalid and needs to be inactivated.
  • The facility completes a Correction Request Form for inactivation of the record.
  • ***The facility submits the inactivation request*** (action #1 in the flowchart in Figure 2-1).
  • The State accepts and processes the inactivation request, and the record is inactivated in the State database.
• If the record was invalid because it indicated the wrong resident or wrong reasons for assessment, ***then a new record should be created and submitted for the correct resident and correct reasons for assessment*** (action #1 in the flowchart in Figure 2-1).

2.1.1.2 Modifying a Valid MDS Record in the State MDS Database

A facility performs a Data Correction to modify a valid record that resides in the State database when the record is known to have data errors. A record is considered to be ***valid*** if it meets all of the following conditions:

1) It is not a ***test record***.
2) The record corresponds to an ***actual event***.
3) The record identifies the ***correct resident***.
4) The record identifies the ***correct reasons for assessment***.
5) The record is ***required*** to be submitted.

Because a record is valid, it does not mean that it is error-free. One or more MDS

Items in a valid record may have data errors. Data errors can occur for a variety of reasons, including transcription errors, data entry errors, errors caused by software products, or item coding errors. The modification process is used to correct an MDS record that resides in the State MDS database, to insure that the data in the State database matches the status of the resident as of the event date (Assessment Reference Date in MDS Item A3a, Discharge Date in MDS Item R4, or Reentry Date in MDS Item A4a). As with completion of the original assessment, when modifying assessment information, the facility is responsible to ensure the participation of the appropriate health care professionals.

In most cases, a modification to an MDS assessment will not involve changing any of the dates in the prior, erroneous record. The facility should ***not*** update the assessment completion dates (MDS Items R2b, VB2, and VB4) to the time that the correction is being made. Even when an assessment is modified, the completion dates should usually remain unchanged from the original completion times. The only time a date should be modified is when the facility can substantiate that the date itself was in error.

Once a record has been modified, the modification cannot be "undone" by resubmitting an earlier version of the record. A modification can only be "undone" by submitting an additional modification for that record including the desired, correct information

2.1.1.2(a) Tracking Form Error

If the record in error in the State database is a Discharge or Reentry Tracking Form, then the facility need only make a Data Correction. No Clinical Correction is relevant, since Clinical Correction only applies to assessments. For a tracking form error, the facility corrects a copy of the tracking form and also completes a Correction Request Form, indicating that the required action is modification. The facility transmits a submission record to the State (action #2 in flowchart in Figure 2-1). This submission record contains the information on the Correction Request Form and the corrected tracking form information (see "Overview of MDS Submission Record" in Figure 1-1 in Section 1.9). When the State accepts and processes this modification request, the error is corrected in the State database. See Scenario 2/6 in Table 2-2.

2.1.1.2(b) Assessment Error: Determine whether the Error was Major and Uncorrected

Whenever it is determined that an MDS assessment record in the State database requires modification, facility staff must make an additional determination regarding whether the error was ***Major*** and was not corrected with a subsequent assessment. An error is Major if the resident's overall clinical status has been misrepresented on the

MDS assessment or if the care plan derived from the assessment does not suit the resident's needs. A Major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan.

2.1.1.2(b.a) When the Assessment Error Was Not a Major Error or Has Been Corrected

If an assessment error was not Major or if a Major error has been corrected by a subsequent assessment, then the facility need only make a Data Correction and submit a correction request to modify the erroneous record in the database. There is no need for a new assessment to be performed as a Clinical Correction step.

In this case, the facility corrects a copy of the assessment and also completes a Correction Request Form, indicating that the requested action is modification (Correction Request Form Item AT2 = 1). The facility submits a Modification Request record to the State (action #2 in flowchart in Figure 2-1). This Modification Request record contains the information on the Correction Request Form and the corrected assessment information (see "Overview of MDS Submission Record" in Figure 1-1 in Section 1.9). When the State accepts and processes the modification request, the error is corrected in the State database. Refer to **Scenario 2/6** in Table 2-2 for the steps involved in correcting a Data Error in the State MDS database when there is no Major error.

Table 2-2.

SCENARIO 2/6
Valid Tracking Form or Assessment Record with Inaccuracies in the State Database But There Is No Uncorrected Major Assessment Error

- The facility discovers that a valid MDS assessment or tracking form record contains inaccurate information.
- Investigation indicates that the record with inaccurate assessment information has already been transmitted and accepted into the State MDS database.
- The assessment or tracking form record in the State database is inaccurate and needs to be modified.
  - The facility corrects a copy of the assessment or tracking form and also completes a Correction Request Form for modification of the record.
  - ***The facility submits the corrected assessment or tracking form together with a request for modification*** (action #2 in the flowchart in Figure 2-1).
  - The State accepts and processes the modification request, and the error is corrected in the State database.
- For tracking form errors: No further action is required.
- For assessment errors: Appropriate health professional(s) review the resident's clinical record and determine that the assessment errors were not Major or, if Major, whether they have been corrected by a subsequent assessment.
  - No Major uncorrected error has resulted.
  - ***No further action is required by the facility*** (action # 6 in the flowchart in Figure 2-1).

2.1.1.2(b.b) When a Major Assessment Error Has NOT Been Corrected on a Subsequent Assessment

If the assessment error is Major, ***and*** it has ***not*** been corrected on a subsequent assessment, the facility should complete and transmit ***both*** the correction request to modify the erroneous record in the database, ***and*** a new Significant Change or Significant Correction assessment, whichever is appropriate. To correct the erroneous assessment, the facility submits the corrected assessment, together with a Correction Request Form indicating that the required action is modification (see "Overview of MDS Submission Record" in Figure 1-1 in Section 1.9). When the State accepts and processes the modification request, the error is corrected in the State database.

2.1.1.2(b.b.a) No Significant Change in Status Has Occurred

Facility staff must also determine whether the resident's status has actually changed since the erroneous assessment was completed. If the resident has not experienced a Significant Change in Status, in addition to submitting the modification request, the facility must also perform and transmit a ***Significant Correction assessment***. Refer to **Scenario 2-7** in Table 2-3 for the steps involved in correcting an assessment in the MDS database that contains an uncorrected Major error but a significant change in status has not actually occurred.

Table 2-3.

SCENARIO 2/7
Valid Assessment Record with Inaccuracies in the State Database, Uncorrected Major Error Is Present, But No Significant Change Has Occurred

- The facility discovers that a valid MDS assessment record contains inaccurate information.
- Investigation indicates that the record with this inaccurate information has been transmitted and accepted into the State MDS database.
- The assessment record in the State database is inaccurate and needs to be modified.
  - The facility corrects a copy of the assessment and also completes a Correction Request Form for modification of the record.
  - ***The facility submits the corrected assessment together with the modification request*** (action # 2 in the flowchart in Figure 2-1).
  - The State accepts and processes the modification request, and the error is corrected in the State database.
- Appropriate health professional(s) review the resident's clinical record and determine that no subsequent MDS assessment has corrected the inaccurate items in the erroneous assessment.
  - Appropriate health professional(s) then review the resident's clinical record and determine that the erroneous MDS assessment information either provided an inaccurate description of the resident's overall clinical status or led to an inappropriate care plan (an uncorrected Major error has occurred).
    - Appropriate health professional(s) then investigate if there has been a significant change in resident status since the last assessment.
    - Appropriate health professional(s) determine that there has been no significant change.
      - ***A new Significant Correction assessment is completed to reassess the resident, the care plan is updated, and the new assessment is submitted to the State*** (action # 7 in the flowchart in Figure 2-1).

2.1.1.2(b.b.b) Significant Change in Status Has Occurred.

If the resident has experienced a Significant Change in Status, in addition to submitting a modification request, the facility must also perform and transmit a ***Significant Change in Status assessment***. In any instance in which a resident experiences a significant change in status, regardless of whether there was also an error on the previous assessment, a Significant Change in Status assessment must be completed by the end of the 14th calendar day following the determination that a significant change occurred. Refer to **Scenario 2/8** in Table 2-4 for the steps involved in correcting an assessment in the MDS database that contains an uncorrected Major error, when the resident also experienced a Significant Change in Status since the Assessment Reference Date (MDS Item A3a) of the original, erroneous assessment.

Table 2-4.

SCENARIO 2/8
Valid Assessment Record with Inaccuracies in the State Database, Uncorrected Major Error Is Present, and a Significant Change Has Occurred

- The facility discovers that a valid MDS assessment record contains inaccurate information.
- Investigation indicates that the record with this inaccurate information has already been transmitted and accepted into the State MDS database.
- The assessment record in the State database is inaccurate and needs to be modified.
  - The facility corrects a copy of the assessment and also completes a Correction Request Form for modification of the record.
  - ***The facility submits the corrected assessment together with the modification request*** (action # 2 in the flowchart in Figure 2-1).
  - The State accepts and processes the modification request, and the error is corrected in the State database.
- Appropriate health professional(s) review the resident's clinical record and determine that no subsequent MDS assessment has corrected the inaccurate items in the erroneous assessment.
  - Appropriate health professional(s) then review the resident's clinical record and determine that the erroneous MDS assessment information either provided an inaccurate description of the resident's overall clinical status or led to an inappropriate care plan (an uncorrected Major error has occurred).
    - Appropriate health professional(s) then investigate if there has been a significant change in resident status since the last assessment.
    - Appropriate health professional(s) determine that there has been a significant change.
      - ***A new Significant Change assessment is completed to reassess the resident, the care plan is updated, and the new assessment is submitted to the State*** (action # 8 in the flowchart in Figure 2-1)

A Note on Significant Change and Significant Correction Assessments. Significant Change in Status assessments and Significant Correction assessments are entirely new assessments of the resident, based upon a new Assessment Reference Date (MDS Item A3a). If the assessment in error was a ***comprehensive*** assessment, requiring RAPs and Triggers, (the primary reason for assessment in MDS Item AA8a indicated the assessment as an Admission, Annual, Significant Change in Status, or Significant Correction of Prior Full), then a new Significant Correction of a Prior ***Full*** assessment or Significant Change assessment must be completed (whichever is appropriate), including RAPs, Triggers and care plan update. If the assessment in error was NOT a comprehensive assessment (the primary reason for assessment in MDS Item AA8a indicated the assessment as a Quarterly Review or Significant Correction of Prior Quarterly assessment), then a new Significant Correction of a Prior ***Quarterly*** Assessment must be performed and submitted.

Note that "Significant Correction of Prior" assessments are still a viable and important part of the clinical correction process. ***The "Data Correction" process in no way precludes the need for "Significant Correction of Prior" assessments.*** If the resident's overall clinical status has been mis-assessed or if the current care plan does not suit the resident's needs, then a Major error has occurred. A new "Significant Correction of Prior" assessment must be performed using a new observation period and a new Assessment Reference Date, and the resident's care plan must be updated using information from the new assessment. A data modification cannot be used in lieu of this important clinical process. If an MDS assessment has already been accepted by the State MDS system and it contains a Major error, then ***both*** a correction request to correct that record in the database ***and*** a new "Significant Correction of Prior" assessment must be submitted. If the erroneous record in the database is not corrected, facility reports generated for standard system applications (e.g., QIs and payment) will not be accurate. In addition the new "Significant Correction of Prior" assessment is necessary, in order to ensure accurate assessment and care planning based on the resident's current status. A data correction cannot simply substitute for a "Significant Correction of Prior" assessment. To do so would jeopardize the clinical integrity of the MDS process.

Similarly, ***the data modification process in no way precludes the need for "Significant Change in Status" assessments.*** The data modification process is used to make corrections to insure that the data in the State database matches the actual assessed condition of the resident at the time of assessment (e.g., Assessment Reference Date at MDS Item A3a). If a resident experienced a significant change in status since that time, a data modification is completely inappropriate for reporting this change. Rather, when a resident has experienced a significant change in status, a

new "Significant Change in Status" assessment must be performed, using a new observation period and a new Assessment Reference Date, and the resident's care plan must be updated using information from this new assessment. A data modification cannot be used in lieu of a "Significant Change in Status" assessment, or to record changes in a resident's condition. To do so would jeopardize the clinical integrity of the MDS process.

2.1.2 Errors in MDS Records That Are Not In the State MDS Database

Records that are not in the State MDS database include those that have not been data entered, have not been transmitted, or have been transmitted and rejected. The automated mechanism for correcting records in the MDS database at the State and the use of the MDS Correction Request Form, as outlined above, is not appropriate for records that have not been accepted. When an error occurs in an MDS record (assessment, or Discharge or Reentry Tracking form) that has not been accepted in the database, facility staff should determine whether the record should be ***excluded*** from submission or ***corrected*** and then submitted.

2.1.2.1 Excluding an Invalid MDS Record Not in the State MDS Database

The facility should exclude (not submit) an invalid record that should not actually have been completed. A record is considered to be ***invalid*** in any of the following cases:

1) It was a ***test record*** inadvertently created as a production record.
2) The event did not occur.
   a. The record created does not correspond to any actual event. For example, a discharge tracking form was created for a resident, but there was no actual discharge. There was ***no event***.
   a. The record created identifies the ***wrong resident***. For example, a discharge tracking form was completed for the wrong person.
   b. The record created identifies the ***wrong reasons for assessment***. For example, a Reentry Tracking Form was created when the resident was discharged.

When an invalid record does not reside in the MDS database at the State, the record should not be submitted and use of the MDS Correction Request Form does not apply. Refer to **Scenario 3** in Table 2-5 for a more detailed explanation of the process of excluding an invalid record from submission. Cases necessitating exclusion of an invalid MDS record should be rare.

When an invalid record is not in the State database, there is usually no reason to maintain paper or electronic documentation for that record, and invalid paper and electronic records can usually be discarded. Maintaining an invalid record may be

misleading in terms of the course of clinical events for the resident. The one exception involves an invalid record that was used at any point as a basis for care planning or provision for a resident. If the invalid record had such clinical use, then the record must be retained in the resident's clinical record but with its validity problems clearly indicated.

Table 2-5.

SCENARIO 3 **Invalid Record Not in the State Database**
• The facility discovers that an invalid MDS assessment or tracking form record has been created. The record is invalid because it represents a test record, the event did not occur, or the record indicated the wrong resident or wrong reasons for assessment (MDS Items AA8a and AA8b). • Investigation indicates that this invalid record has not been transmitted to the State or has been transmitted but rejected. The information is not in the State database.   • ***The facility simply excludes this record from any further submission*** (action # 3 in the flowchart in Figure 2-1). • If the record was invalid because it indicated the wrong resident or wrong reasons for assessment, ***then a new record should be created and submitted for the correct resident and correct reasons for assessment*** (action #3 in the flowchart in Figure 2-1).

2.1.2.2 Correcting a Valid MDS Record Not in the State MDS Database

A facility should perform an in-house correction when a valid record has not been accepted and is known to have data errors. A record is considered to be ***valid*** if it meets all of the following conditions:

1) It is not a test record.
2) The record corresponds to any actual event.
3) The record identifies the correct resident.
4) The record identifies the correct reasons for assessment.
5) The record is required to be submitted.

Because a record is valid, it does not mean that it is error-free. One or more MDS items in a valid record may have data errors. The facility may have become aware of these data errors because the record has been rejected by the State, or the facility may

have discovered these data errors on its own

Data errors in unaccepted records can occur for a variety of reasons, including transcription errors, data entry errors, errors caused by software products, or item coding errors. When a facility detects an error in a valid MDS record that resides only in the facility (i.e., that has not been accepted by the MDS database at the State), the facility should correct the record and ensure its accuracy relative to the resident's status as of the event date (MDS Item A3a for assessments, Item A4a for Reentry Tracking forms, or Item R4 for Discharge Tracking forms). After correction, the facility should edit the record using HCFA specified edits; and then submit the corrected record to the State. It may also be appropriate to update the resident's care plan, based on the revised record. Since the erroneous record does not reside in the MDS database at the State, the electronic and paper records are corrected in the facility and use of the MDS Correction Request Form does not apply. Paper records should be corrected using standard medical records procedures. That is, the person responsible for the accuracy of the information enters the correct response, draws a single line through the previous response without obliterating it, and initials and dates the corrected entry.

In most cases, an in-house correction to an MDS assessment will not involve changing any of the dates in the record. The facility should ***not*** update the assessment completion dates (MDS Items R2b, VB2, and VB4) to the time that the correction is being made. Even when an assessment is corrected, the completion dates should usually remain unchanged from the original completion times. The only time a date should be modified is when the facility can substantiate that the date itself was in error.

2.1.2.2(a) Tracking Form Error

Whenever a valid Discharge or Reentry Tracking Form record is found to be in error but has not been accepted by the standard MDS system at the State, then the facility need only correct that record in-house and submit it. See Scenario 4/5 in Table 2-6.

2.1.2.2(b) Assessment Error: Determine whether it has been Eight or More Days since Assessment Completion

Whenever a valid MDS assessment record is found to be in error but has not been accepted by the standard MDS system at the State, the facility should correct and submit that assessment record. Also the facility should take additional action if the error was detected outside of the standard MDS editing time frame of seven days after the final assessment completion date. Final assessment completion is defined as the date the care planning decision process was completed (MDS Item VB4) for comprehensive assessments, or the date the RN Coordinator certified that the MDS

was complete (MDS Item R2b) for non-comprehensive assessments. In accordance with the clinical process, the facility must use the information contained in the Resident Assessment Instrument as the basis for the resident's care plan, and the care plan must be developed, or revised if appropriate, within seven days after final completion of an assessment.

2.1.2.2(b.a) Assessment Error Detected during Seven Day Editing Period

If an assessment error is detected within the seven day editing time frame, the facility should correct the record and ensure its accuracy relative to the resident's status as of the event date (MDS Item A3a for assessments); edit the record using HCFA specified edits; and then submit the corrected record to the State. It may also be appropriate to update the resident's care plan, based on the revised assessment record. When the erroneous record does not reside in the MDS database at the State, the electronic and paper records are corrected in-house, and the MDS Correction Request Form should not be used. Refer to **Scenario 4/5** in Table 2-6 for the steps involved in correcting an assessment error detected within seven days of record completion, for valid assessment records that are not in the State MDS database.

Table 2-6.

SCENARIO 4/5 **Valid Unaccepted Tracking Form Record with Inaccuracies or Valid Unaccepted Assessment Record Still in the Editing Phase with Inaccuracies**

• The facility discovers that a valid MDS assessment or tracking form record contains inaccurate information, and, if an assessment, the assessment is still in the standard editing phase within 7 days of the final completion date (VB4 for a comprehensive assessment or R2b for other assessments).
  • Facility staff corrects the assessment or tracking form information in-house, checks to insure its accuracy, and checks that the record passes standard HCFA edits.
  • ***The facility submits the assessment or tracking form record to the State*** (action # 4 in the flowchart in Figure 2-1).
• For tracking form errors: No further action is required.
• For assessment errors: Appropriate ***health professional(s) revise the resident's care plan, if appropriate, based on the corrected assessment information*** (action # 5 in the flowchart in Figure 2-1).

2.1.2.2(b.b) Assessment Error Detected Eight or more Days since Completion

If the error is detected eight or more days after the assessment was completed (i.e., after the editing phase), the assessment record should be corrected and submitted. Additional action may also be required, depending on whether the error was Major.

Determine whether the Assessment Error was Major and Uncorrected. Whenever an MDS assessment record that resides only in the facility is found to be in error, and the error was detected eight or more days after the assessment final completion date (MDS Item VB4 for comprehensive assessments or Item R2b for other assessments), the facility must correct and submit that record and update the care plan if necessary. ***In addition***, the facility must determine whether the assessment error was ***Major*** and not corrected with a subsequent assessment. An error is Major if the resident's overall clinical status has been misrepresented on the assessment or the care plan derived from the assessment does not suit the resident's needs. A Major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's status and an appropriate care plan.

2.1.2.2(b.b.a) When the Assessment Error was not a Major Error or has been Corrected

If the assessment error was ***not*** Major or if a Major error has been corrected by a subsequent assessment, then the facility need only correct and submit the record. There is no need for a new assessment to be performed as a Clinical Correction step. Refer to **Scenario 4/6** in Table 2-7 for the steps involved in correcting unaccepted assessment records with errors that have been discovered eight or more days after the assessment final completion date (MDS Item VB4 for comprehensive assessments or Item R2b for other assessments) when there is no uncorrected Major error present.

Table 2-7.

SCENARIO 4/6
Valid Assessment Record with Inaccuracies Is No Longer in the Editing Phase, Is Not in the State Database, And There Is No Uncorrected Major Error Present

- The facility discovers that a valid MDS assessment record contains inaccurate information, and the assessment is no longer in the standard editing phase. That is, the error has been discovered 8 or more days after the final completion date (VB4 for a comprehensive assessment or R2b for other assessments).
- Investigation indicates that the inaccurate assessment record has not been submitted to the State or was submitted but rejected.
  - Facility staff corrects the assessment information in-house, checks to insure its accuracy, and checks that the record passes standard HCFA edits.
  - ***The facility submits the assessment record to the State*** (action # 4 in the flowchart in Figure 2-1).
- Appropriate health professional(s) review the resident's clinical record and determine that no subsequent MDS assessment has corrected the inaccurate items in the erroneous assessment.
  - Appropriate health professional(s) then review the resident's clinical record and determine that the assessment errors were not Major.
  - No Major uncorrected error has resulted.
    - ***No further action is required by the facility*** (action # 6 in the flowchart in Figure 2-1).

2.1.2.2(b.b.b) When a Major Assessment Error has NOT been Corrected on a Subsequent Assessment

If the error is Major, ***and*** it has ***not*** been corrected on a subsequent assessment, the facility should correct and transmit the assessment to the State In addition, facility staff must ***also*** determine whether the resident's status has actually changed since the erroneous assessment was completed, and if it has, whether this was a Significant Change in Status. The facility must then perform and transmit a new Significant Change or Significant Correction assessment, whichever is appropriate.

2.1.2.2(b.b.b.a) No Significant Change in Status has Occurred

If the error is MAJOR, ***and*** it has ***not*** been corrected on a subsequent assessment, ***and*** the resident has ***not*** experienced a Significant Change in Status, then in addition to transmitting the corrected assessment to the MDS database at the State, the facility must also perform and transmit a ***Significant Correction of Prior assessment***. Refer to ***Scenario 4/7*** in Table 2-8 for the steps involved in correcting a Major error in an assessment that only resides in the facility, that was discovered eight or more days after the final completion date for the assessment (MDS Item VB4 for comprehensive assessments or Item R2b for other assessments), but no significant change has actually occurred.

If the assessment in error was a ***comprehensive*** assessment, requiring RAPs, Triggers and care plan review, (the primary reason for assessment in MDS Item AA8a indicated the assessment as an Admission, Annual, Significant Change in Status, Significant Correction of Prior Full), then a new Significant Correction of a Prior ***Full*** assessment must be completed, including RAPs, Triggers and care plan review. If the assessment in error was NOT a comprehensive assessment (the primary reason for assessment in MDS Item AA8a indicated the assessment as a Quarterly or Significant Correction of prior Quarterly Assessment), then a new Significant Correction of a Prior ***Quarterly*** Assessment must be performed and submitted.

Table 2-8.

SCENARIO 4/7
Valid Assessment Record with Inaccuracies Is No Longer in the Editing Phase, Is Not in the State Database, Uncorrected Major Error Is Present, But No Significant Change Has Occurred

- The facility discovers that a valid MDS assessment record contains inaccurate information, and the assessment is no longer in the standard editing phase. That is, the error has been discovered 8 or more days after the final completion date (VB4 for a comprehensive assessment or R2b for other assessments).
- Investigation indicates that the inaccurate record has not been submitted to the State or was submitted but rejected.
  - Facility staff corrects the assessment information in-house, checks to insure its accuracy, and checks that the record passes standard HCFA edits.
  - ***The facility submits the assessment record to the State*** (action # 4 in the flowchart in Figure 2-1).
- Appropriate health professional(s) review the resident's clinical record and determine that no subsequent MDS assessment has corrected the inaccurate items in the erroneous assessment.
  - Appropriate health professional(s) then review the resident's clinical record and determine that the erroneous MDS assessment information either provided an inaccurate description of the resident's overall clinical status or led to an inappropriate care plan (an uncorrected Major error has occurred).
    - Appropriate health professional(s) then investigate if there has been a significant change in resident status since the last assessment.
    - Appropriate health professional(s) determine that there has been no significant change.
      - ***A new Significant Correction assessment is completed to reassess the resident, the care plan is updated, and the new assessment is submitted to the State*** (action # 7 in the flowchart in Figure 2-1).

2.1.2.2(b.b.b.b) A Significant Change in Status has Occurred

If the assessment error is Major, ***and*** it has ***not*** been corrected on a subsequent assessment, ***and*** the resident has experienced a Significant Change in Status since the Assessment Reference Date (MDS Item A3a) of the original, erroneous assessment, then in addition to transmitting the corrected assessment to the MDS database at the State, the facility must also perform and transmit a ***Significant Change in Status assessment***. Refer to ***Scenario 4/8*** in Table 2-9 for the steps involved in correcting a Major error in an assessment that resides only in the facility, when the resident also experienced a Significant Change in Status.

Whenever a resident experiences a significant change in status, regardless of whether there was also an error on the previous assessment, a Significant Change in Status assessment must be completed by the end of the 14th calendar day following the determination that a significant change occurred. Significant Change in Status assessments and Significant Correction of Prior assessments are entirely new reassessments of the resident, based upon a new Assessment Reference Date (MDS Item A3a).

Table 2-9.

SCENARIO 4/8
Valid Assessment Record with Inaccuracies Is No Longer in the Editing Phase, Is Not in the State Database, Uncorrected Major Error Is Present, And a Significant Change Has Occurred

- The facility discovers that a valid MDS assessment record contains inaccurate information, and the assessment is no longer in the standard editing phase. That is the error has been discovered 8 or more days after the final completion date (for a comprehensive assessment or R2b for other assessments).
- Investigation indicates that the inaccurate record has not been submitted to the State or was submitted but rejected.
  - Facility staff corrects the assessment information in-house, checks to insure its accuracy, and checks that the record passes standard HCFA edits.
  - ***The facility submits the assessment record to the State*** (action # 4 in the flowchart in Figure 2-1).
- Appropriate health professional(s) review the resident's clinical record and determine that no subsequent MDS assessment has corrected the inaccurate items in the erroneous assessment.
  - Appropriate health professional(s) then review the resident's clinical record and determine that the erroneous MDS assessment information either provided an inaccurate description of the resident's overall clinical status or led to an inappropriate care plan (an uncorrected Major error has occurred).
  - Appropriate health professional(s) then investigate if there has been a significant change in resident status since the last assessment.
  - Appropriate health professional(s) determine that there has been a significant change.
    - ***A new Significant Change assessment is completed to reassess the resident, the care plan is updated, and the new assessment is submitted to the State*** (action # 8 in the flowchart in Figure 2-1).

2.2 Correction Policy Matrix

The correction policy summary matrix in Table 2-10 provides a quick reference to all the correction policy scenarios. This matrix provides a summary checklist of all the actions required for each scenario.

Table 2-10
Correction Policy Summary Matrix

SCENARIO	ACTIONS BY FACILITY							
	1 Inactivate Record in State Database	2 Modify Record in State Database	3 Exclude Record from Submission	4 Correct Orig. Record In-House and Submit	5 Revise Care Plan if Necessary	6 No Sign. Change or Correct. Required	7 Perform and Submit Sign. Correction Assessment and Update Care Plan	8 Perform and Submit Sign. Change Assessment and Update Care Plan
1 Invalid record at State	✔							
2/6 Minor error at State		✔				✔		
2/7 Uncorr. Major error at State, no sign. change		✔					✔	
2/8 Uncorr. Major error at State, sign. change		✔						✔
3 Invalid record in-house			✔					
4/5 Record in edit phase in-house				✔	✔			
4/6 Minor error in-house				✔		✔		
4/7 Uncorr. major error in-house, no sign. change				✔			✔	
4/8 Uncorr. Major error in-house, sign. change				✔				✔

CHAPTER 3

Item-by-Item Guide to the MDS Version 2.0 Correction Request Form

3.1 Correction Request Form for the RAI, Version 2.0

The Correction Request Form is being implemented as part of a new Correction Policy that allows facilities to correct erroneous MDS data previously submitted and accepted into the State MDS database. The form is completed and submitted by the facility to request modification or inactivation of an erroneous MDS record (assessment, discharge, or reentry). This Correction Request Form is associated with the federally mandated Resident Assessment Instrument, Version 2.0 and as such, is required for use as indicated, by all nursing homes certified to participate in Medicare or Medicaid. A copy of the Correction Request Form is included at the end of Chapter 1 of this manual.

The MDS Version 2.0 Correction Request Form contains two sections: the PRIOR RECORD section and the CORRECTION ATTESTATION section. This form is to be completed when an inaccuracy is detected in an MDS record (assessment or Discharge or Reentry Tracking form) that resides in the MDS database at the State (that is, the record passed HCFA's standard edits and has been accepted by the State MDS system).

3.2 Overview: Item-by-Item Guide to the MDS Version 2.0 Correction Request Form

This Item-by-Item Guide is to be used in conjunction with the MDS Version 2.0 Correction Request Form. A copy of this form is provided at the end of Chapter 1. The Correction Request Form is being implemented as a part of a series of MDS system enhancements, developed to provide a mechanism for facilities to correct errors in MDS records in the MDS database at the State, and to provide a mechanism to inactivate invalid records that should not have been submitted to the State. These enhancements are intended to remedy concern about the accuracy of data in the State and national MDS databases when errors are accepted into the system without an option or a mechanism to correct.

3.3 How to Use This Guide

Use this Guide alongside the MDS Version 2.0 Correction Request Form, keeping the form in front of you at all times. The information in this guide should facilitate the

accurate completion and coding of the Correction Request Form.

3.4 The Standard Format Used in This Guide

To facilitate completion of the MDS Version 2.0 Correction Request Form, and to ensure consistent interpretation of Items, this guide presents the following types information for each Item, as appropriate:

Intent: Reason(s) for including the Item (or set of Items) on the Correction Request Form, including discussions of how the information will be used by facility staff to identify whether a request should be made for an *Inactivation* or a *Modification* of an MDS record (assessment, or Discharge or Reentry Tracking form).

Definition: Explanation of key terms.

Process: Sources of information and methods for determining the correct response for an Item.

Coding: Proper method of recording each response, with explanations of individual response categories.

3.5 Item-by-Item Instructions for Completing the MDS Correction Request Form

To facilitate your use of this guide as a reference tool, the Item-by-Item instructions follow the sequence of Items on the HCFA MDS Version 2.0 Correction Request Form.

3.5.1 Prior Record Section

Intent: This section is used to locate the erroneous assessment or tracking form record in the State database.

Process: Obtain the information for this section from the previously submitted, erroneous assessment or tracking form.

Coding: Record the information ***exactly as submitted and accepted into the State database***, even if the information is incorrect or requires correction.

Example: The MDS assessment was submitted and accepted for Joan L. Smith. When the encoder "key entered" the assessment, he typed "John" by mistake. To correct this error, the facility should complete a Correction Request Form and a corrected assessment form. When completing the Resident's Name Item in the Prior Record Section of the Correction Request Form, "John" should be entered. This will permit the State system to locate the previously submitted assessment that is being corrected. If the correct name "Joan" were entered, the State system would not be able to locate the prior assessment.

The correction to modify the name from "John" to "Joan" will be recorded in the corrected assessment that will accompany the Correction Request Form in the submission record. The corrected assessment must include all items appropriate for that assessment, not just the corrected name. Both the Correction Request Form information and the corrected assessment information will then be encoded into a single submission record, according to the MDS data specifications (see "Overview of MDS Submission Record" in Figure 1-1 in Section 1.9). This submission record will then be transmitted to the State to cause the desired correction to be made.

Prior_AA1. Resident Name

Definition: The name exactly as submitted in MDS item AA1 on the prior, erroneous record.

Coding: Enter in the following order -- a.) first name, b.) middle initial, c.) last name, d.) Jr./Sr.

PRIOR_AA2. Gender

Coding: Enter the gender "1" or "2" exactly as submitted in MDS item AA2 on the prior, erroneous record.

PRIOR_AA3. Birthdate

Coding: Fill in the boxes with the appropriate date exactly as submitted in

MDS item AA3 on the prior, erroneous record. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example, January 2, 1918 should be entered as:

0	1		0	2		1	9	1	8

PRIOR_AA5a. Social Security Number

Coding: Fill in the boxes with the resident's social security number exactly as submitted in MDS item AA3 on the prior, erroneous record. Begin writing one number per box starting with the left most box. Recheck the number to be sure you have written the digits correctly.

PRIOR_AA8. Reasons for Assessment

a. Primary Reason for Assessment

Coding: Enter the two digit code corresponding to the primary reason for assessment exactly as submitted in MDS item AA8a on the prior, erroneous record.

b. Codes for Assessments Required for Medicare PPS or the State

Coding: Enter the one digit code corresponding to the special Medicare PPS or State reason for assessment exactly as submitted in MDS item AA8b on the prior, erroneous record. If this item was blank on the prior, erroneous assessment, then it should be blank on this item on the Correction Request.

PRIOR_DATE. (Complete one *ONLY*)

Intent: To document the reference date for the prior record. If the prior, erroneous record is an assessment, complete the PRIOR_A3a Assessment Reference Date only. If the prior record is a discharge tracking form, complete the PRIOR_R4 Discharge Date only. If the

prior record is a reentry tracking form, complete the PRIOR_A4a date of reentry only.

Coding: Fill in the boxes with the appropriate date exactly as submitted on the prior, erroneous assessment or tracking form record. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example, May 3, 2000 should be entered as:

0	5		0	3		2	0	0	0

PRIOR_A3a. Assessment Reference Date

Coding: If the prior, erroneous record was an assessment (PRIOR_AA8a equals 01, 02, 03, 04, 05, 10, or 00), enter the Assessment Reference Date exactly as submitted in the prior MDS item A3a. Leave blank if the prior record was a discharge or reentry (PRIOR_AA8a is equal to 06, 07, 08, or 09).

PRIOR_R4. Discharge Date

Coding: If the prior, erroneous record was a Discharge Tracking Form (Prior_AA8a equals 06, 07, or 08), enter the Discharge Date exactly as submitted in the prior MDS item R4. Leave blank if the prior record was an assessment or reentry (PRIOR_AA8a equals 01, 02, 03, 04, 05, 09, 10, or 00).

PRIOR_A4a. Date of Reentry

Coding: If the prior, erroneous record was a Reentry Tracking form (PRIOR_A4a equals 09), enter the date of reentry exactly as submitted in the prior MDS item A4a. Leave blank if the prior record was an assessment or discharge (PRIOR_AA8a equals 01, 02, 03, 04, 05, 06, 07, 08, 10, or 00).

3.5.2 Correction Attestation Section

Intent: These items collect attestation information describing the reason for the correction request and whether the request is to modify or to inactivate an MDS assessment or tracking form record that has been previously submitted and accepted by the State database.

AT1. Attestation sequence number

Intent: To identify the total number of correction requests following the original assessment or tracking record, including the present request. Note that Item AT1 is used to track successive correction requests. It the past, MDS Item A3b was intended for this purpose. With the inclusion of Item AT1 on the Correction Request Form, MDS Item A3b will not be needed and has been made inactive in the standard system at the State.

Coding: For the first correction request for an MDS record, code a value of 01 (zero-one); for the second correction request, code a value of 02 (zero-two); etc. With each succeeding request, AT1 is incremented by one. For values between one and nine, a leading zero should be used in the first box.

AT2. Action Requested

Intent: To identify whether the correction request is being submitted to modify or to inactivate a prior, erroneous assessment or tracking form.

Process: If the request is to MODIFY an assessment or tracking form, then the facility should take the following actions:

1. Obtain and make a copy of the prior assessment or tracking form to modify.
2. Make the necessary corrections to this copy of the prior form using appropriate medical records correction procedures--recording the correct value, drawing a line through the previous response without obliterating it, and initialing and dating the corrected entry.

3. Complete both the Prior Record and Correction Attestation sections of the Correction Request Form. Be sure to exactly transcribe the necessary information from the prior assessment or tracking form into the Prior Record Section of the Correction Request Form.
4. Attach the Correction Request Form to the corrected prior assessment or tracking form.
5. Encode all of the information from both the Correction Request Form and the corrected assessment or tracking form into a single submission record according to the MDS data specifications and submit this record to the State. For a modification, the submission record includes all items on the corrected prior assessment or tracking form, not just the corrected values for the items in error.
6. Retain in the resident's clinical record:
   a. the signed Correction Request Form,
   b. the attached corrected assessment or tracking form,
   c. documentation indicating the date that errors were detected,
   d. documentation substantiating the accuracy of the correction, relative to the resident's status as of the Assessment Reference Date (MDS Item A3a) of the original assessment, the Discharge Date (MDS Item R4) of the original discharge tracking form, or the Reentry Date (MDS Item A4a) of the original reentry tracking form.

If the request is to INACTIVATE an assessment or tracking form, the facility should take the following actions.

1. Obtain and make a copy of the prior assessment or tracking form to inactivate.
2. Complete both the Prior Record and Correction Attestation sections of the Correction Request Form. Be sure to exactly transcribe the necessary information from the prior assessment or tracking form into the Prior Record Section of the Correction Request Form.
3. Attach the Correction Request Form to the prior assessment or tracking form that is to be inactivated.

4. Encode the information from the Correction Request Form into a submission record according to the MDS data specifications and submit this record to the State. For an inactivation, the submission record only includes information from the Correction Request Form. Items from the associated assessment or tracking form to be inactivated must be blank
5. Retain the signed Correction Request Form and the attached assessment or tracking form in the clinical records with substantiating documentation. This documentation should indicate the date the errors were detected.

Coding: Enter a "1" if the action requested is to MODIFY an assessment or tracking form. Enter a "2" if the requested action is to INACTIVATE an assessment or tracking form.

AT3. Reasons for Modification

Intent: To identify the reason(s) for the error(s) that require modification of the prior, erroneous assessment or tracking form record that has been previously submitted and accepted by the State database.

Definition: **a. Transcription error** -- Includes any error made recording MDS assessment or tracking form information from other sources. An example is transposing the digits for the patient's weight (e.g., recording "191" rather than the correct weight of "119" that appears in the medical record).

b. Data entry error -- Includes any error made while encoding MDS assessment or tracking form information into the facility's computer system. An example is a "key punching" error where the response to a minutes of therapy item (P1b) is incorrectly encoded as "3000" minutes rather than the correct number of "0030" minutes recorded on the MDS form.

c. Software product error -- Includes any error created by the encoding software, such as, "storing" an item with the wrong format (e.g., misplacing the decimal point in an ICD-9 code in item I3) or "storing" an item in the wrong position in an electronic MDS record.

submitted for the wrong person.

3. The record submitted identifies the ***wrong reasons for assessment***. For example, a Reentry Tracking Form was submitted when the resident was discharged.

c. Inadvertent submission of inappropriate record -- An example would be submission of a ***non-required*** assessment performed for an "in-house" quality improvement or quality assurance program being conducted by the facility.

d. Other reason requiring inactivation -- Includes any other reason for error that causes a prior assessment or tracking form record to require inactivation under the Correction Policy. Facility staff should describe the "other error" in the space provided on the form.

Coding: If the Action Requested (AT2) = "2", check all that apply. Leave all blank if AT2 = "1".

AT5. Attesting Individual

Intent: To identify the facility staff attesting to the completion and accuracy of the corrected information.

Coding: Enter the name of the facility staff attesting to the completion and accuracy of the corrected information. Begin with the first name (at Item AT5a), followed by the last name (at Item AT5b), and then their title. In addition, when the form is complete, the facility staff must sign the Correction Request Form, certifying the completion and accuracy. The entire form should be completed and signed within 14 days of detecting an error in an MDS record that resides in the State MDS database. A hard copy of this form, including the signature of the attesting facility staff, must be attached to the modified or inactivated MDS record and retained in the resident's record, ***regardless*** of whether the facility maintains a paper or an electronic clinical record system (see Section 1.10).

d. Item coding error -- Includes any error made coding an MDS item, such as choosing an incorrect code for an ADL self-performance item in G1 (e.g., choosing a code of "4" in G1aA for a resident who requires limited assistance and should be coded as "2"). Item coding errors may result when an assessor makes an incorrect judgement or misunderstands the RAI coding instructions.

e. Other error -- Includes any other reason for error that causes a prior assessment or tracking form record to require modification under the Correction Policy. An example would be when a record is prematurely submitted prior to final completion of editing and review. Facility staff should describe the "other error" in the space provided on the form.

Coding: If the Action Requested (AT2) = "1", check all that apply. Leave all blank if AT2 = "2".

AT4. Reasons for Inactivation

Intent: To identify the reason(s) requiring inactivation of an invalid assessment or tracking form record that has been previously submitted and accepted by the MDS database at the State.

Definition: **a. Test record submitted as a production record** -- An example is a fictitious assessment or tracking form record which was fabricated to test a software product and then inadvertently submitted to the State as a production record.

b. Event did not occur -- Includes submission of an assessment or tracking form record describing an event that did not occur. The event did not occur if any of the following conditions apply:

1. The record submitted does not correspond to an actual event. For example, a discharge tracking form was submitted for a resident, but there was no actual discharge. There was ***no event***.
2. The record submitted identifies the ***wrong resident***. For example, a discharge tracking form was completed and

AT6. Attestation Date

Intent: To identify the date the attesting facility staff certified the completion and accuracy of the corrected information.

Coding: Do not leave any boxes blank. Enter the date the facility staff certified the completion and accuracy. For a one digit month or day, place a zero in the first box. For example, July 2, 2000, should be entered as:

0	7		0	2		2	0	0	0

APPENDIX A

DEFINITION OF IMPORTANT DATES IN THE RAI PROCESS

TYPE OF RECORD	TARGET (OR EVENT) DATE	FINAL COMPLETION DATE
Asmt. Not Comprehensive (quarterly or full assessment without Section V)	A3a	R2b (all required assessment items complete)
Comprehensive Asmt (includes Section V)	A3a	VB4 (final completion of comprehensive assessment and care plan)
Discharge Tracking Form	R4	R4
Reentry Tracking Form	A4a	A4a
Correction Request Form	----	AT6

APPENDIX B

ALTERNATIVE CORRECTION POLICY FLOWCHARTS

The "Correction Policy Flowchart" in Figure 2-1 (page 2-2) depicts all of MDS correction policy in a single, composite flowchart. This composite flowchart has been split into three separate flowcharts in this appendix. Figure B-1, "Overall Correction Policy Flowchart", presents an overview of correction policy. Figure B-2, "Data Correction Policy Flowchart", presents the details of the MDS data correction policy. Figure B-3, "Clinical Correction Policy Flowchart", presents the details of the MDS clinical correction policy.

Note that the content of the three flowcharts in this appendix is exactly the same as the composite flowchart in Figure 2-1. The three flowcharts together represent an alternative picture of the same information. These flowcharts have been developed for inclusion in this manual, for use by those who prefer to view the data and the clinical correction processes separately. When using this alternative, the actions in all three charts must be traced as appropriate, in order to insure that an important component of the correction process has not been overlooked.

Figure B-1. OVERALL CORRECTION POLICY FLOWCHART

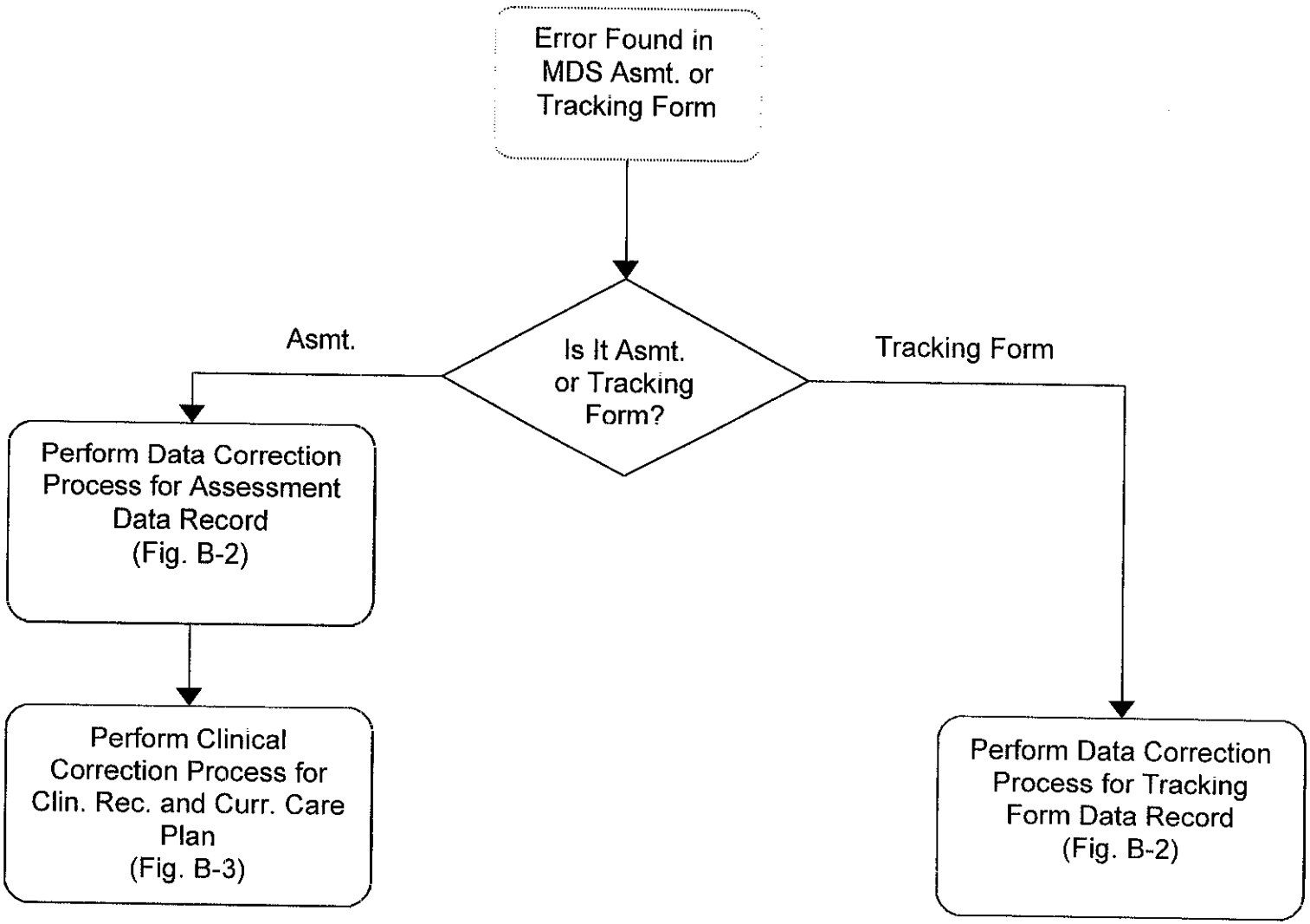
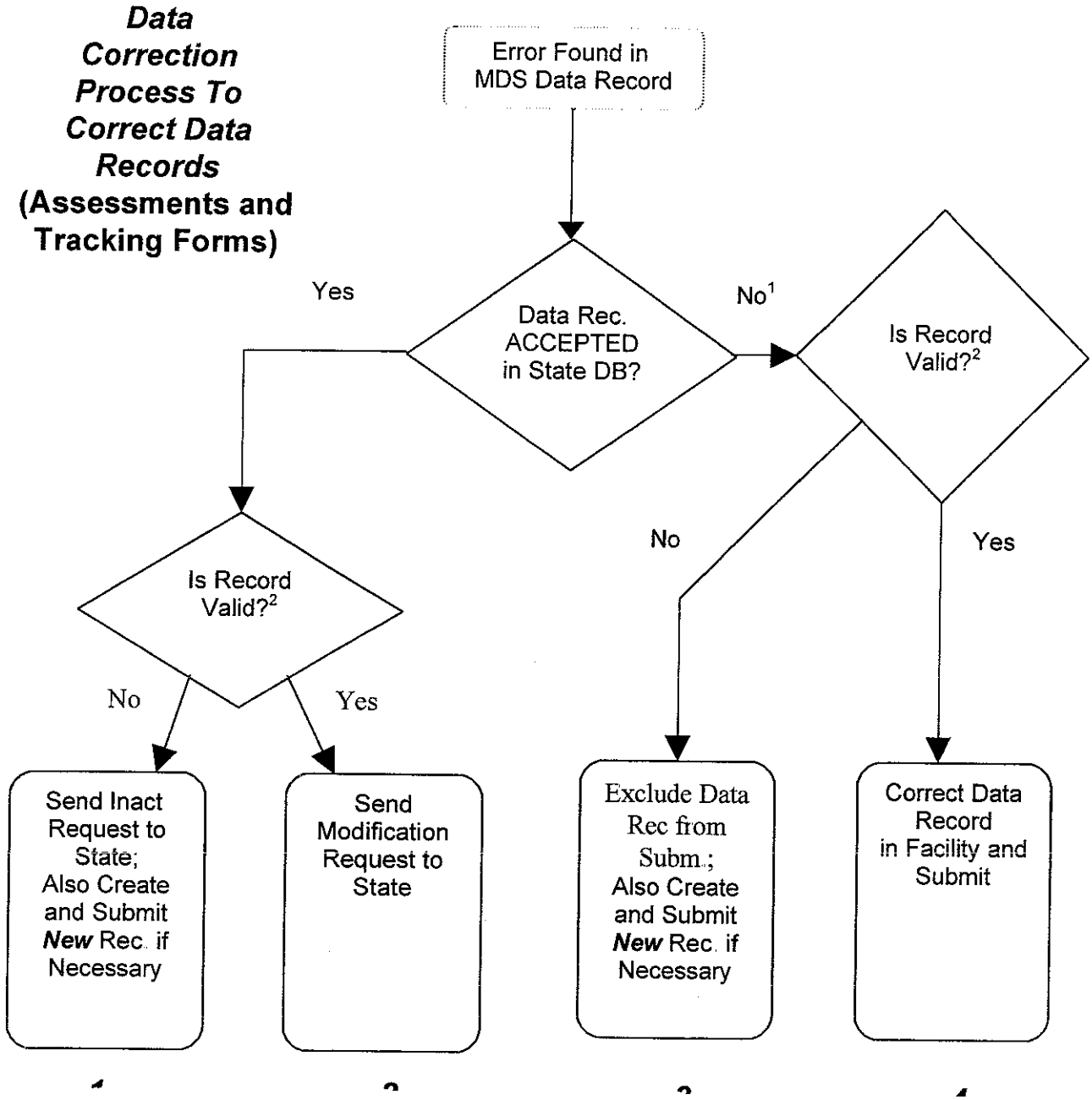


Figure B-2. DATA CORRECTION POLICY FLOWCHART

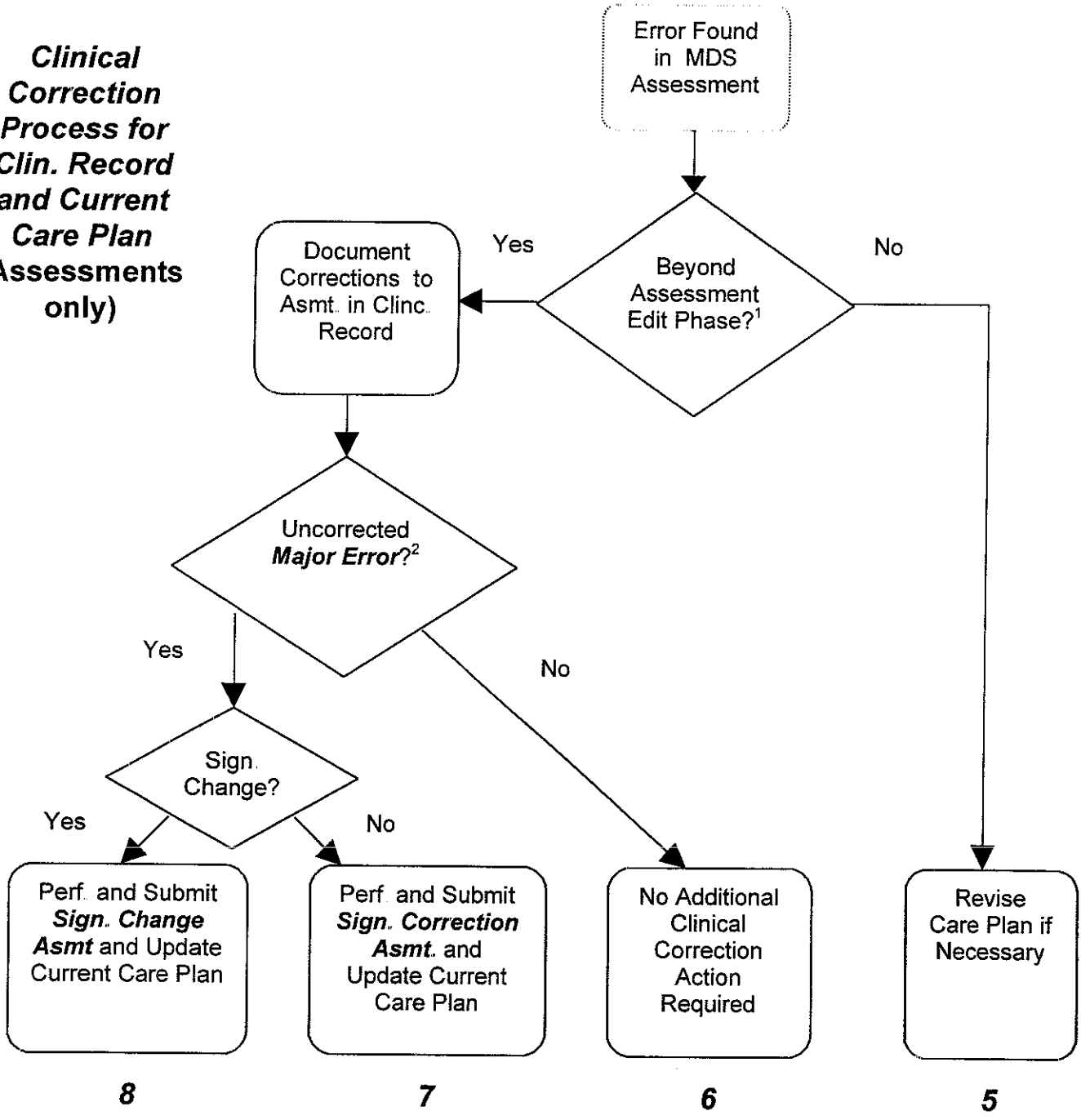


[1] Record has not been data entered, has not been submitted, or has been submitted and rejected

[2] The record is ***valid*** if ***event occurred***,***resident*** and ***reasons for assessment*** are correct, and ***submission is required***.

Figure B-3. CLINICAL CORRECTION POLICY FLOWCHART

***Clinical Correction Process for Clin. Record and Current Care Plan* (Assessments only)**



[1]An assessment is in the edit phase until more than 7 days have passed since the final completion date of the assessment (VB4 for a comprehensive and R2b for all other assessments) or the assessment has been submitted and accepted into the State database, whichever occurs sooner.

[2]The assessment in error contains a Major error which has not been corrected by a subsequent assessment